Delaware Medical Journal

ESTABLISHED 1776

Official Publication of the Medical Society of Delaware

1789 INCORPORATED

Peace on Earth, Good Will Toward Men . . .

DECEMBER, 1960

for every phase of cough... comprehensive relief

AMBENYL® EXPECTORANT

AMBENYL EXPECTORANT quickly comforts the coughing patient because it is formulated to relieve all phases of cough due to upper respiratory infections or allergies. Combining Ambodryl®—potent antihistaminic; Benadryl®—the time-tested antihistaminic-antispasmodic; and three well-recognized antitussive agents, AMBENYL EXPECTORANT:

• soothes irritation • quiets the cough reflex • decongests nasal mucosa • facilitates expectoration • decreases bronchial spasm • and tastes good, too.

Each fluidounce of AMBENYL EXPECTORANT ◈ contains:

Ambodryl® hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	56 mg.
Dihydrocodeinone bitartrate	⅙ gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied: Bottles of 16 ounces and 1 gallon.

Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children ½ to 1 teaspoonful. 27140

◈ Exempt narcotic

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

PARKE-DAVIS

FOUNDED 1776

MEDICAL SOCIETY OF DELAWARE

INCORPORATED 1789

Delaware Medical Journal

Official Publication of the Medical Society of Delaware

EDITORIAL AND BUSINESS OFFICES
1925 LOVERING AVENUE, WILMINGTON 6, DELAWARE

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Footnotes and bibliographies should conform to the style of the Cumulative Index Medicus, published by the National Library of Medicine and the American Medical Association.

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CONTENTS

Entered as second-class matter June 28, 1929, at the Post Office at Wilmington, Delaware, under the Act of March 3, 1879.
Issued monthly.

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In rheumatoid arthritis with diabetes mellitus. A 54-year-old diabetic with a four-year history of arthritis was started on DECADRON, 0.75 mg./day, to control severe symptoms. After a year of therapy with 0.5 to 1.5 mg. daily doses of DECADRON, she has had no side effects and diabetes has not been exacerbated. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

*From a clinical investigator's report to Merck Sharp & Dohme.

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Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

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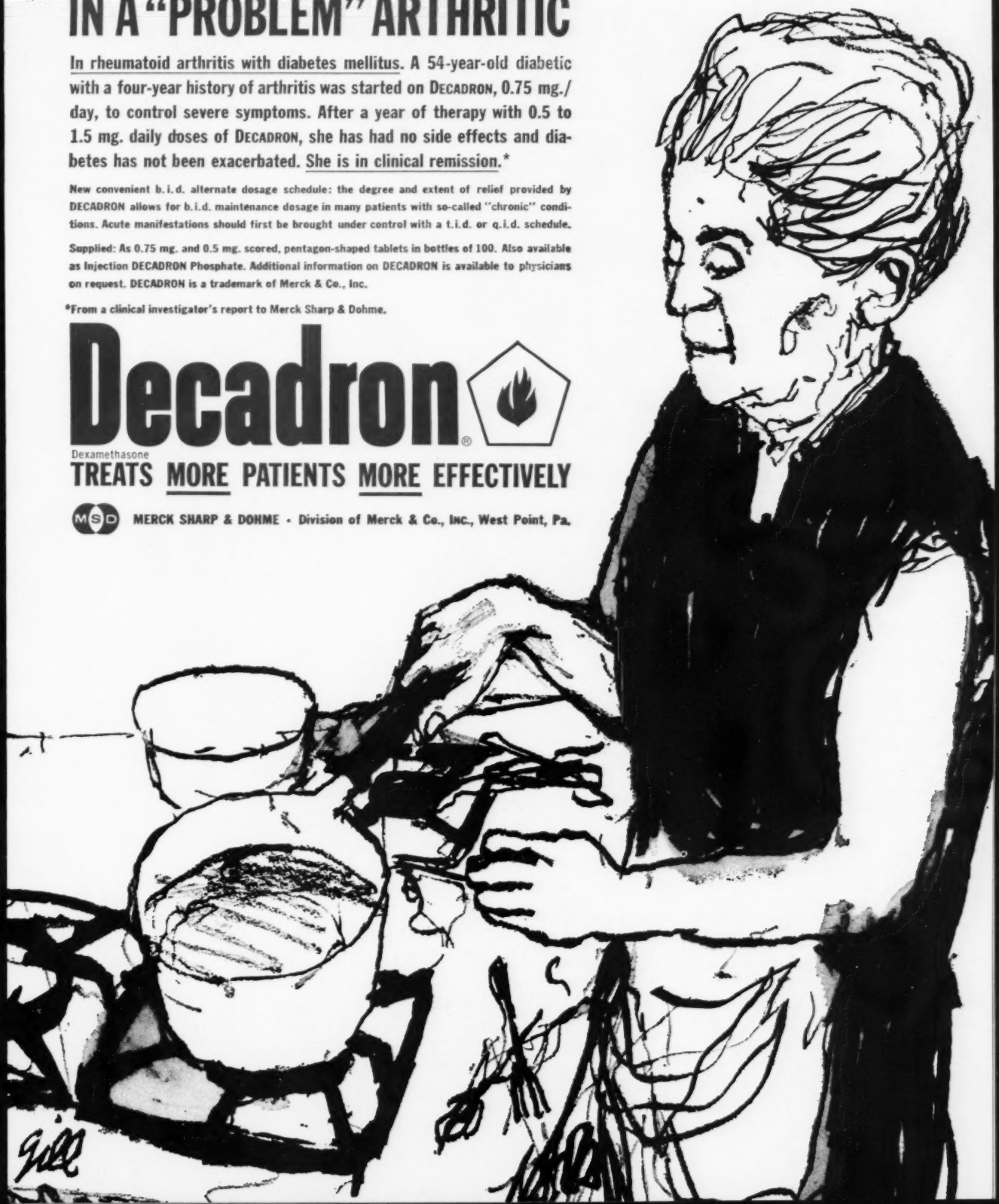

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New!—A Manual and Atlas for the General Surgeon

Marble—The Hand

This unusual book is aimed at the needs of the general practitioner, general surgeon and industrial physician—the men who see hand injuries first. Full page plates and explicit text give you quick instructions on treating every type of hand injury you are likely to see—from *lacerations* and *puncture wounds* to *fractures* and *crushing injuries.*

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Meares—A System of Medical Hypnosis

Here is sound advice on how to apply hypnosis safely and effectively in your everyday practice. Dr. Meares gives step-by-step instructions for each method of induction: by direct stare; by suggestions for relaxation; by arm levitation; etc. He gives practical help on choosing the right method of induction for a particular case.

You'll find suggestions for clinical use of hypnosis in relief of pain and insomnia; as an aid to diagnosis; and as an anesthetic agent. The value of hypnosis in obstetrics and delivery is clearly discussed—with methods, problems and complications pointed up in rich detail. There are useful hints on applying hypnosis in the treatment of various gynecologic disorders, chronic illness, psychogenetic obesity, and alcoholism.

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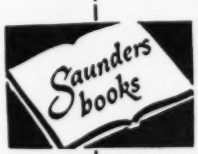

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ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

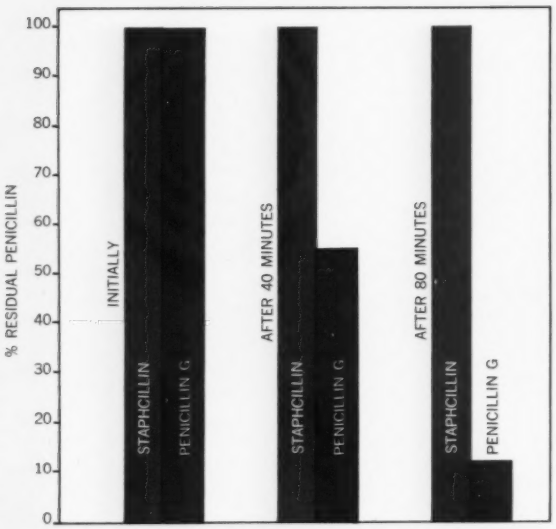
sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASE
WHICH INACTIVATES
OTHER PENICILLINS

Bristol™

NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN



In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE – The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

BRISTOL LABORATORIES • SYRACUSE, NEW YORK

Division of Bristol-Myers Company

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

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MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antomicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

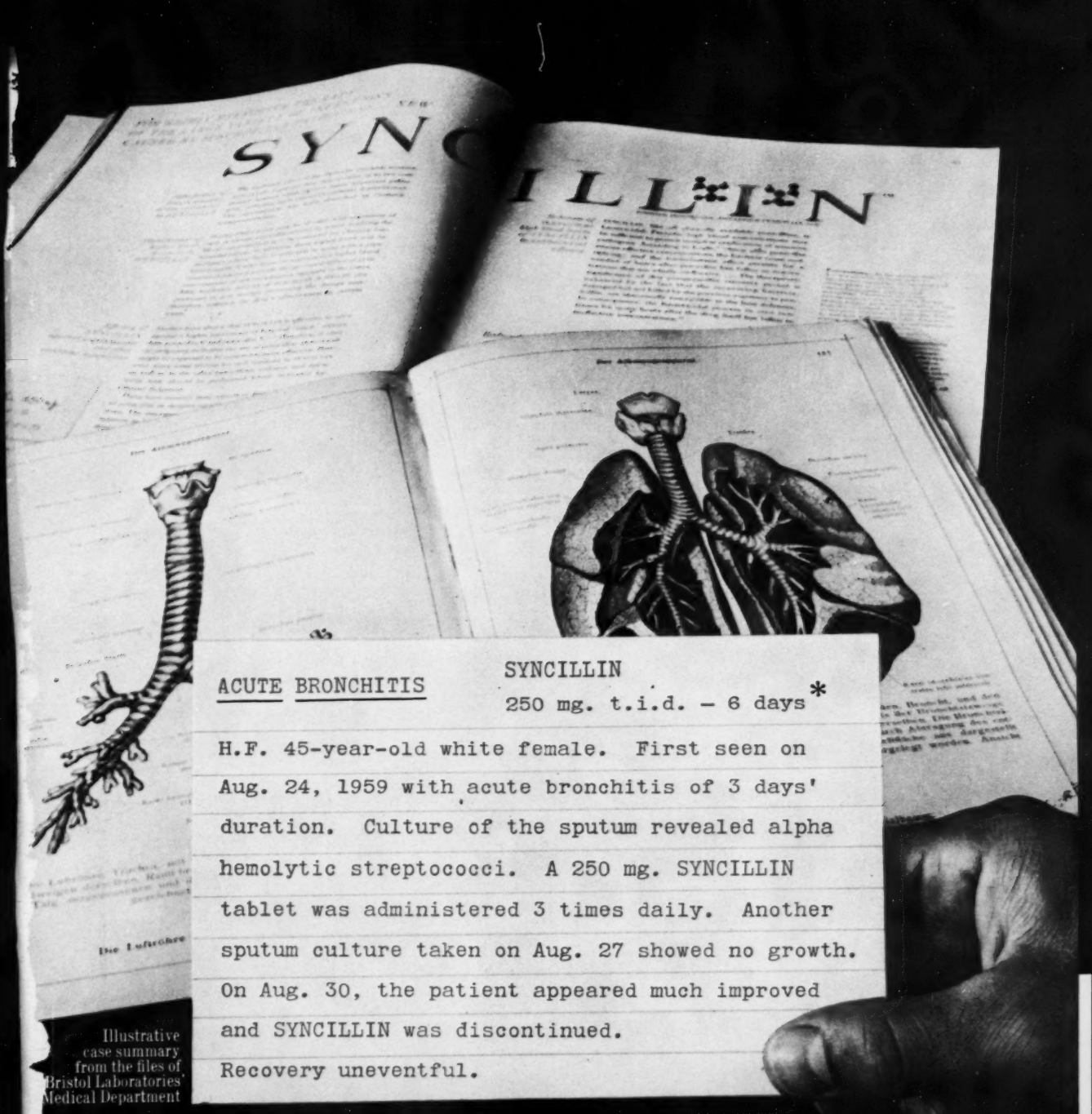
PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

List 79502 – 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company



ACUTE BRONCHITIS

SYNCILLIN
250 mg. t.i.d. – 6 days*

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued. Recovery uneventful.

Illustrative case summary from the files of Bristol Laboratories' Medical Department

THE ORIGINAL phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

FIRST SYNTHESIZED AND MADE AVAILABLE BY BRISTOL LABORATORIES

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

*Streptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever and as prophylaxis against bacterial endocarditis in susceptible patients.

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, Div. of Bristol-Myers Co., SYRACUSE, N.Y.

NEW *Antirheumatic Analgesic*

PLANOLAR*

for Rheumatoid Arthritis

Planolar combines the cumulative antirheumatic and anti-inflammatory action of Plaquenil® with the prompt analgesic action of aspirin.

Each tablet contains: **Plaquenil 60 mg.**
Aspirin 300 mg. (5 grains)

Plaquenil "...the preferred antimalarial drug for treatment of disorders of connective tissue..."[1]

Aspirin belongs to "...the most useful group of drugs for rheumatoid arthritis."[2]

WRITE:
for detailed information (clinical experience, side effects, precautions, etc.)

HOW SUPPLIED: ***Bottles of 100 tablets.***

Winthrop LABORATORIES
New York 18, N. Y.

DOSAGE: Adults, 2 tablets two or three times daily. After two or three months of therapy, the patient may no longer need the added benefit of aspirin. A maintenance regimen of Plaquenil sulfate alone (from 200 to 400 mg. daily) may then be substituted.

REFERENCES:

1. Scherbel, A. L.; Schuchter, S. L., and Harrison, J. W.: Cleveland Clin. Quart. 24:98, April, 1957.
2. Waine, Hans: Arthritis, rheumatoid, in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Co., 1959, p. 565.

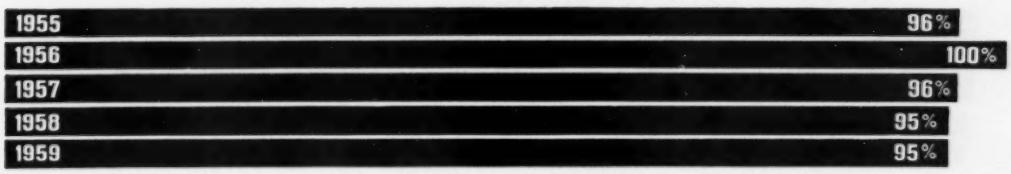
*Planolar, trademark

resistant
staphylococci
among
outpatients
emerge
less
frequently...
disappear
more
readily

CHLOROMYCETIN®

chloramphenicol, Parke-Davis

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*



These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. 10360

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

PARKE-DAVIS

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

A special formulation for those troublesome cases of acute nonspecific diarrhea

DONNAGEL®-PG

Donnagel® with paregoric equivalent

Provides greater assurance of more comprehensive relief in acute self-limiting diarrheas through the time-tested effectiveness of two outstanding antidiarrheals—DONNAGEL and a paregoric equivalent. *Tastes good, too!*

Each 30 cc. (1 fl. oz.) of DONNAGEL-PG contains:

Powdered opium U.S.P. (equivalent to paregoric 6 ml.)	24.0 mg.
Kaolin	6.0 Gm.
Pectin	142.8 mg.
Natural belladonna alkaloids	
hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz.

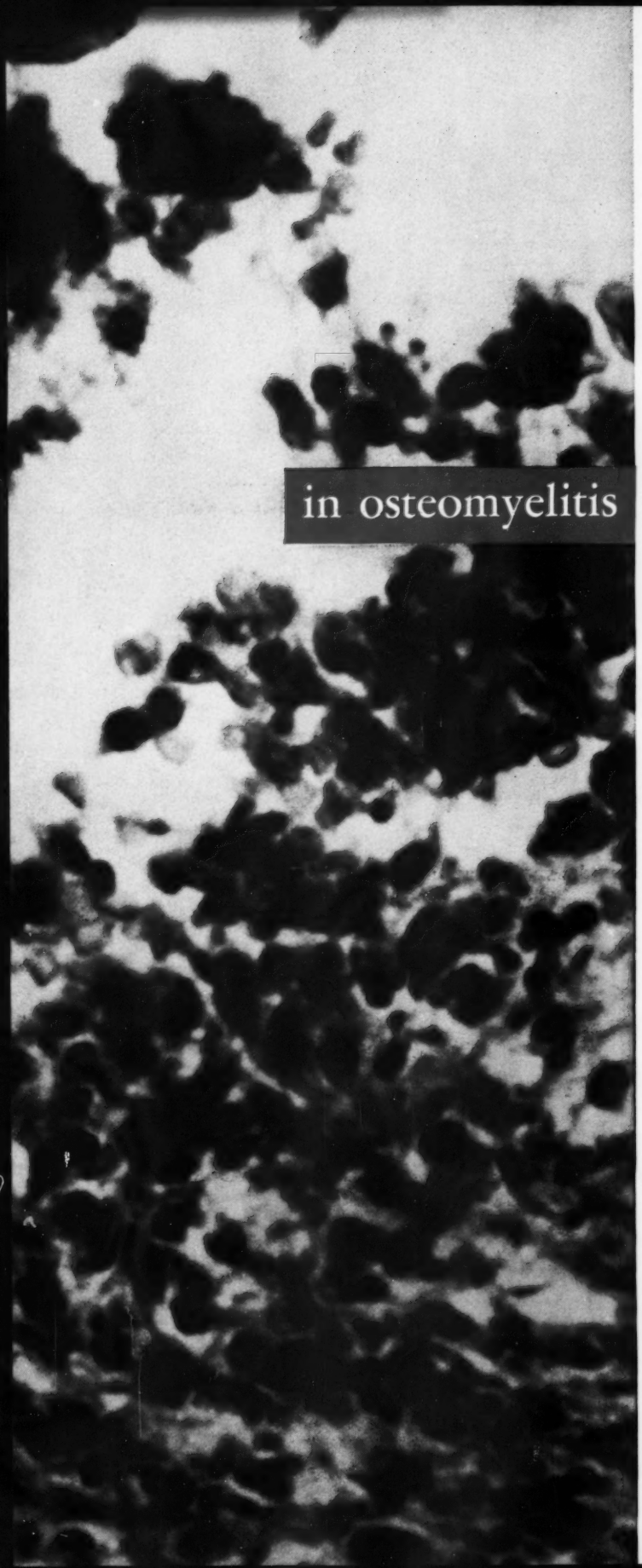
Also available:

DONNAGEL® with NEOMYCIN—for control of bacterial diarrheas.

DONNAGEL®—the basic formula—when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC. Robins
RICHMOND 20, VIRGINIA

Bone section: erosion and purulent exudate



in osteomyelitis

Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including ubiquitous staphylococci. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Trademark, Reg. U. S. Pat. Off.

The Upjohn Company
Kalamazoo, Michigan

Upjohn

Panalba*

your broad-spectrum antibiotic of *first* resort

In over five years

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked,* coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

WALLACE LABORATORIES / *Cranbury, N. J.*

CM-2537

*TRADE-MARK

# of clinical use...

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain

stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

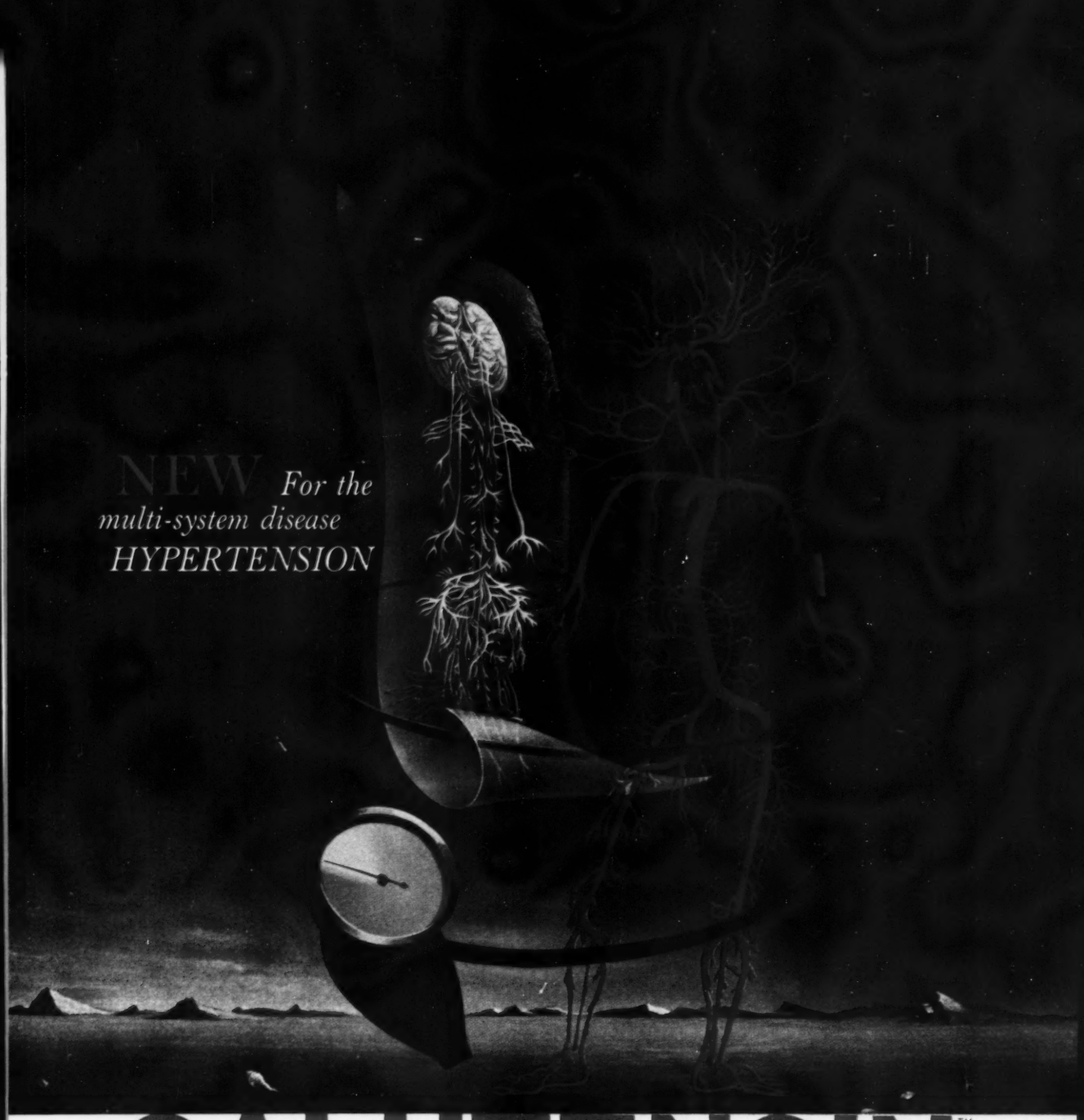
soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

WALLACE LABORATORIES • Cranbury, N. J.



SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)—a saluretic-antihypertensive	50 mg.
Reserpine—a tranquilizing drug with peripheral vasorelaxant effects	0.125 mg.
Protoveratrine A—a centrally mediated vasorelaxant	0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

DECEMBER, 1960

NUMBER 12

VOLUME 32

Delaware Medical Journal

Address*

TO THE MEDICAL SOCIETY OF DELAWARE

JAMES E. MARVIL, M.D., PRESIDENT

1960 may be called a year of decision in regard to American medicine. Never before have so many worked so hard to force upon the American public the first step toward the socialization of medicine.

The United States is almost alone in retaining the system of private enterprise where each community takes care of its own medical problems. Now that it is too late, in England, Austria, certain Canadian provinces and in many other places, we hear of great dissatisfaction with socialized medicine. I personally have observed socialized medicine in England where really ill patients are neglected because so much time is taken up with patients who are not ill but take advantage of medical services because they are free.

We still have time and should take every opportunity to present facts as we know them. We are opposed to political medicine and we can see only harm from it. Our elected representatives want to know our opinion and are influenced greatly by our presenting material to help them vote properly.

Your President, your Executive Secretary and your Chairman of our Legislative Committee, have attended a national conference sponsored by the A.M.A. on legislative matters in St. Louis, Missouri in October, 1959.

*Presented at the Annual Meeting, September 9, 1960, Lewes, Delaware.

We have, during the past year, also visited our legislature in Dover and our Senators in Washington relative to legislation regarding health matters. We found them willing to listen and anxious for our views regarding health legislation. So far they have voted in the best interests of proper medical care. We have found that our elected representatives look to us for guidance in these matters.

We should also explain to our patients in the same way, what will be lost for them as far as proper medical care is concerned. They should be told that what may appear to be a free handout may actually cost them dearly in the end by substituting political medicine for what is the best medical service in the world.

It has been demonstrated clearly that if we fail to furnish the best medical care, then legislation will be passed to attempt to force the situation.

What can we do?

1. We should get our own house in order.
2. We should provide medical care of such quality that there will be no demand for socialized medicine.
3. We should provide care at fees the indigent, the low income group and the restricted income group, such as the aged, can afford.

Delaware is 15% below the United States average in physicians, which causes certain dissatisfaction when patients are not able to reach physicians who are already overworked.

In December, 1959, the Council of our society authorized the investigation of the need for and the feasibility of a medical school for Delaware. Following a suggestion from Governor Boggs that our society should confer with the University of Delaware regarding the matter, the President, Vice President and two others met in April with Dr. Perkins and several of his board of trustees.

Our Committee and Dr. Perkins' Committee had arrived at the same conclusion by previous independent studies. Briefly the findings were:

1. Present medical graduates (6860 annually) are too few for present needs and in ten years will be 30% below present physician-population ratio.

2. Foreign graduates who have been filling deficits will be sharply curtailed due to the Educational Council for Foreign Graduates restrictions.

3. There are 700-800 vacancies in third and fourth year United States medical school classes at present.

4. That a two-year medical school in Delaware would be desirable, especially since our state's populations growth is so rapid and since Delaware is presently 15% below the United States national average in physicians.

5. Dr. Perkins' estimate for cost is two million dollars for buildings and 14 million dollars for annuities. He stated that a medical school would fit in well with the present university graduate program.

Formerly many of us felt that a medical school would be too expensive and would be impossible for Delaware to build and maintain.

The cost of building a two-year school would not be more than construction of two or three miles of super highways. Which is most important to us? American medicine is facing a desperate crisis and one of our greatest needs is more physicians so that we can continue giving the best medical care.

Our society could help provide:

1. Teaching staff

2. Help in fund raising.

There is considerable lay interest in such a project, especially if research is connected with the medical school. Many of us believe that funds could be raised for such a project without great difficulty, with the help of some federal aid.

It has been pointed out that Delaware students should have equal opportunities to study medicine. Due to so many applicants, schools are inclined to take their own residents first.

So far we have been fortunate in having many foreign trained physicians come to us. With the new Educational Council for Foreign Medical Graduates restrictions, the number will be sharply curtailed.

It has not been necessary to import foreign lawyers, dentists, clergy, et cetera and we should be able to train our own physicians.

E. Vincent Askey, M.D., president of the A.M.A., in his address to the House of Delegates at Miami emphasized the need for training more physicians. He especially emphasized the importance of expanding present medical schools and building new ones. Dr. Arthur Fleming of H. E. W. has introduced a bill in congress to aid present and new medical schools.

As physicians we have a duty—to take the lead in pointing out the need for better medical care. Many lay persons are interested in a Delaware Medical School and are waiting for the physicians to demonstrate our interest.

PROCEEDINGS OF THE HOUSE OF DELEGATES*

MEDICAL SOCIETY OF DELAWARE

The Meeting of the House of Delegates of the Medical Society of Delaware was called to order at the Henlopen Hotel, Rehoboth, Delaware, at 7:15 o'clock p.m., Thursday, September 8, 1960, President James E. Marvil, M.D., presiding.

A roll call was taken by Secretary Cannon and a quorum declared.

The minutes of the last session were accepted as printed in the Journal.

PRESIDENT MARVIL: We will now hear the report of the officers. The President's Report will be given in greater detail tomorrow during the Presidential address. I would like to say that 1960 has been very active because of the legislation concerning the Forand bill. The officers, the President, the Executive Secretary, the Chairman of the Legislative Committee and several others have been very busy working on that. The President, the Executive Secretary and the Chairman of the Legislative Committee visited St. Louis last October to attend an A.M.A.-sponsored Legislative Conference. You will hear more about that later. That was a three-day conference and it was very effective. We found out a great deal about the Forand Bill.

We have also during the year visited Washington. We were very cordially received by our Senators Frear and Williams, who listened very attentively to our views and voted on health matters the way we thought they should.

Another item which happened this year is that all delegates have received a mimeographed paper in regard to a two-year Medical School which has been proposed for Delaware.

Council authorized the collection of statistics and material about that last year, and during the year we have collected a great deal of material. You will hear a little more about that later. The Council today authorized the continuation of that committee and advised that we make efforts to finance the project without going to the State for help.

PRESIDENT MARVIL: We will now hear the Secretary's report.

Report of the Secretary

The office of the Secretary has been conducted on a current basis during the past year. Minutes of the Committee meetings have been kept. The Secretary has also functioned as Chairman of the Commission on Public Affairs and has held two meetings of the Commission during the year. A third meeting, if necessary, is planned for just prior to the House of Delegates meeting where the Commission will act as a reference committee.

Respectfully submitted,
Norman L. Cannon, M.D., Secretary

The report was accepted.

PRESIDENT MARVIL: I think we all realize how much Norman Cannon has done for this Society, how hard he has worked, and I think a lot of appreciation would certainly be in order.

A motion was passed with a round of applause extending a vote of appreciation to Secretary Cannon.

PRESIDENT MARVIL: The Treasurer's report will now be given.

DR. LEVY: Mr. Chairman, I have here the audit as prepared by Haggerty and Haggerty which is for the year July 31, 1959 to July 31, 1960. They will prepare an audit for an additional five months, from the first of August until the end of December and then furnish us with an additional audit from January 1, 1960 until January 1, 1961 or December 31, 1960, which is a return to our original fiscal year—the calendar year.

According to their report regarding the scope of the examination, they state:

We have made tests of the income and expense factors in the Treasurer's records and those of the Delaware Medical Journal, which we consider necessary in the circumstances.

Report of the Treasurer

MEDICAL SOCIETY OF DELAWARE

GENERAL FUND

Balance Sheet at July 31, 1960

BALANCE, BEGINNING OF YEAR	$10,249.55
RECEIPTS:	
Dues:	
State Society	17,437.00
AMA	9,175.00
Subscriptions—Medical Journal	1,113.00
	27,725.00
Annual session—proceeds of ticket sales	1,132.50
Delaware Academy of General Practice	7.76
Annual session—rent, exhibit space (partial)	400.00
Income from investments —schedule A-1	1,165.05
Medical Journal—rent and stenographer	480.00

*The complete report of the Proceedings of the House of Delegates is on file in the Medical Society office and is available to members for reference.

Reimbursement—annual meeting expense		44.00
Reimbursements—committee expenses		474.19
AMA—1% reimbursement collection of dues		41.50
Employees' withholdings		2,138.82
Medical Journal—payroll taxes and withholdings, etc.		1,132.57
Proceeds—sale of desk and chair		200.00
Rent contribution from Journal		1,250.00
		36,191.39
		$46,440.94

BEGINNING BALANCE AND TOTAL RECEIPTS

DISBURSEMENTS:		
Salaries and Payroll Taxes		$11,644.37
Operations		3,578.20
Office		2,397.98
Travel		2,709.19
Annual Session		1,859.30
Memberships and Contributions		195.00
Other:		
AMA dues	$ 9,175.00	
Withholdings, etc.—due from Journal	1,003.22	
Employees' withholdings	2,294.41	
Accounting	275.00	
Travel advance—New Castle County Medical Society	90.12	
		$12,837.75
Total Disbursements		$35,221.79
Balance, End of Year		$11,219.15

MEDICAL SOCIETY OF DELAWARE

Balance Sheet at July 31, 1960

ASSETS

GENERAL FUND:		
Cash in bank:		
Regular account	$11,219.15	
Savings account	5,314.57	
		$16,533.72
Investment—		
Stocks	12,949.08	
Government bonds	11,073.76	
		24,022.84
Due from State Medical Journal	171.11	
Due from New Castle County Medical Society	90.12	
		261.23
		$40,817.79

LIABILITIES AND FUND BALANCES

GENERAL FUND:		
Liabilities:		
Employees' withholdings and accrued payroll taxes	$ 217.07	
Reserve:		
Defense fund	1,000.00	
Fund balance	39,600.72	
		$40,817.79

Assets of the Delaware Medical Journal (see report of the Publications Committee) are also assets of the Society, as sole owner of the Journal.

The report was accepted.

PRESIDENT MARVIL: The report of the Executive Secretary will be heard next.

Report of the Executive Secretary

A report of the staff to the membership of the Society is at best a highly abbreviated thing. There is no pracical way for me to present to you in concise form the things that have occupied our time for 11 busy months. The months have been busy; more so than in any previous year, as the Society reaches out for new programs, new alliances, and new manifestations of its fundamental principals. Most of these appear in one form or another as part of the committee reports. Staff work played a part in most of the committee's work, and I do not propose to launch into a pointless cataloging of meetings, special problems and details. What I propose to offer you is a birds-eye view of the range of the Society's activities, with few details and many omissions. I hope that you will ask any questions that occur to you.

Electronics Education Programs

Perhaps the most rewarding step taken by the Society this year has been its venture into electronics for postgraduate medical education. The thirty-week series of two-way radio programs provided several thousand physician-hours of education, and was very well received. It will be continued this coming year. Dr. Richardson's report on the measurable value of these programs will be read at tomorrow's general session and should be of interest to you. A supplementary program was the trans-atlantic CPC between the Medical Society of Delaware and Britain's Royal Society of Medicine. This, too, was enjoyed by those who attended, and is now available as a tape-recording. We will be alert for ways to expand our use of electronics to bring postgraduate education to the physician.

Activities in the Field of Aging

It is gratifying to be able to report the evolution of a wide range of activity on the part of the Society in the field of aging. An important educational program was co-sponsored in Baltimore by this and several other state medical societies, with the active participation of the AMA. Press and public representatives were invited from the middle-Atlantic region. Four Delawareans spoke on the aspects of the aging problem, and were joined by similar representatives from other states.

The formation of a local Delaware Joint Council to Improve the Health Care of the Aged, at medical society initiative and leadership, points the way to a broad interprofessional program to improve the lot of the elderly. Dr. Washburn's report on the early activity of this Joint Council will be read shortly, and will show explicitly the directions the group is taking. Close rapport has been maintained between the Governor's Conference and the White House Conference on Aging. The number of physicians participating in the local conference in official capacities and as representatives of organized medicine was most encouraging. The influence of doctors is also being felt in the community councils on aging, as illustrated, for example by Wilmington's, which includes the secretary of the state society, the chairman of the Society's Committees on Medical Service and on Public Laws, other physicians, and the executive secretary of the State Medical Society.

A society staff survey of the welfare patients in the Delaware Hospital has developed information of value in our consideration of these problems. A special aging issue of the Delaware Medical Journal was published, and given wide distribution within and without the profession, in an effort to disseminate useful information. Legislative support has been offered constructive bills for the aged in both the state and national legislatures.

The question of how best to provide for the place of the elderly in our changing society is far from solved. It extends beyond health care, to all facets of human need. Medicine, however, is working actively toward a proper solution, and allegations to the contrary are false and misinformed.

Forand Campaign

It is difficult to evaluate exactly the meaning of this year's victory over Forand-type legislation. There is a strong temptation to call it a decisive victory, which it was not, or to say that it gained nothing but time, which understates the case. Proponents of state medicine timed a strong, well-planned legislative drive to culminate just before the 1960 election campaigns. The stopping of this drive by organized medicine and allied groups demonstrates the effectiveness of physicians when well-organized behind a proper cause. It does not mean that the victory is final, because it is not. For more detailed analysis, I refer you to the Committee on Public Laws, but I want to insert a note concerning the special debt owed by the Society to those physicians who worked actively to preserve the independence of medicine from government regulation, and in particular to Drs. Marvil, LaMotte, Pollak, and Eugene McNinch, who served as key men for this campaign in their respective counties. I should also remind you that when the chips were down in the post-convention session of Congress, both Senator Frear and Senator Williams, Democrat and Republican, stood with medicine's point of view.

Journal

The Executive Secretary continues to manage the business of the Delaware Medical Journal. Two years ago we were able to report the recouping of previous losses, and plans by the Publications Committee to expand and improve the Journal. At the same time, plans were announced to increase the contribution made by the Journal to the financing of the Society, and to balance the finances of the book by increasing funds spent on its production.

All of these plans have been carried out. $2000 a year is now transferred from the Journal directly to the Society's budget, while total production costs have been increased by $10,000 to make the Journal of more value to the membership. Income has also been increased, so that for this year the Journal shows a net gain of somewhat under $100. The book is, I believe, more interesting and more attractive than it has been in the past, due to the efforts of the Committee, the Editor and the Assistant Editor. It is also in sound financial condition.

Revised Medical Practice Act

The revision of Delaware's Medical Practice Act passed this year by the Legislature is a signicant step forward in the delegation to medicine of the right and duty to police itself. It should be considered a part of a national movement toward greater attention by medicine to this phase of its activity. The newly created Committee on Medical Discipline of the AMA, of which Delaware's H. T. McGuire is a member, is evidence of this. A hearing by this Committee in New York on state disciplinary problems on procedures, before which Dr. Gehret of the Board of Medical Examiners and the Executive Secretary testified, gives me the impression that the new code puts Delaware among the best-equipped states in the nation to handle problems of this kind.

Medical Economics

Two items of medical economics deserve the attention of the House of Delegates. First of these is a proposed group contract for members of the Society with Blue Cross-Blue Shield, which can result in a considerable cash savings to those members who elect to participate. A council resolution concerning participation in this plan will be presented to you at this meeting for your consideration and possible endorsement. If you direct that such a plan should be instituted, we shall hope to have it in affect by the end of the year.

Secondly, you will note that the Committee on Medical Economics is recommending the preparation and adoption in Delaware of a Relative Value Fee Schedule. This schedule can best be described as a medicare schedule without fees, but with units which may be converted to dollars by the application of a dollar multiple to the units allocated to a given procedure. The Relative Value Schedule is a valuable tool in negotiation of contracts, since it establishes the value of one procedure to another in terms easily transposable for different applications. Your acceptance of the recommendation of the Committee for adoption of such a schedule would be of potentially great value to the Society, but also carries certain dangers. I call this to your attention for possible discussion at the time the report of the Committee is presented.

Polio Vaccination Campaign

In 1957, the Society began its program of Salk vaccination clinics with the Board of Health and the Delaware Chapters of the National Foundation. It has proved highly successful in terms of both concrete benefit to the public and public relations values realized by the Society. This four-year program concluded in 1960, with about 400,000 Salk shots having been administered to the public in the special clinics alone. This project has resulted in nearly 100% polio vaccination among the 7-19 age group in the state, and in relatively high coverage of other groups of all ages. It is perhaps significant that as the national rate of polio incidence rose this year, Delaware's fell.

Annual Meeting

Technical exhibits have been restored to this year's annual meeting at the direction of the Council. We have split the meeting site between Lewes and Rehoboth in order to accommodate them. This move is less radical than it sounds, since all of the events connected with the scientific session take place in the same building, while the meeting of the House of Delegates and the cocktail party and banquet have been held in different sites and indeed in different cities in the past.

Revenue from exhibits will be $885 this year, a considerable decrease from the figure usually obtained in Wilmington, but up 62% from the last Rehoboth meeting, and offset somewhat by the decreased cost of labor and services. The people of Lewes and Rehoboth have been exceptionally

helpful in their various functions, for which I am grateful.

Unfortunately, exhibit revenue still fails to provide the 50% of the cost of the meeting that would be a desirable minimum, and will probably continue to do so until really good convention facilities are made available at reasonable cost somewhere in the state.

The break in the continuity of our exhibit schedule has resulted in a rather high rate of drop-out among our exhibitors this year. It has been necessary to use some promotion in obtaining new exhibitors. If the technical exhibit is to be continued in the future, as many as possible of these new exhibitors should be converted to long-term attenders. I should like to remind the Society in this connection that the attendance of the exhibitors and the help that they provide in financing the meeting and in offering educational material for physicians who attend is dependent upon each member's accepting the responsibility of visiting the exhibits and providing the contact with physicians for which these firms are paying.

Acknowledgement and appreciation is due Mrs. Winifred S. Donnelly, staff secretary, and Mrs. Melita A. Phillips, assistant editor, for their hard work on behalf of the Society. Each has made a definite contribution, and each has gone beyond the confines of the job to provide the flexibility necessary in this small organization.

In conclusion, I want to express my personal appreciation to the officers and members of each of the county medical societies for their courtesy and hospitality when I have visited them, and to the officers and members of the Medical Society of Delaware for their consideration and support throughout the year.

Respectfully submitted,
Lawrence C. Morris, Jr.
Executive Secretary

The report was accepted.

PRESIDENT MARVIL: I would like to add my personal comment to this report. I think Larry has done a wonderful job and I know that he has worked very hard, I know that his office staff worked very hard, that they couldn't possibly turn out the terrific amount of work they do turn out without a lot of hard work, and I know that all of us appreciate having such competent help to take care of our affairs for us.

I would like to read two telegrams which arrived a little while ago:

The first one is dated New York today, addressed to me:

"Best wishes for a successful meeting. Deep regrets that circumstances make it impossible to be with you. Al Shands."

We are very sorry that he is not able to be here. He is attending a meeting in New York.

The next one is dated today, addressed to me:

"Last minute commitments prevent me from attending your annual meeting. I am indeed sorry since I look forward to being with you. Best wishes for a successful meeting. Allen W. Cowley, President, Pennsylvania Medical Society."

We are very sorry that Dr. Cowley and his wife are not able to attend with us.

The next order of business will be reports of Standing Committees. The first is the Budget Committee, Dr. Levy.

Report of the Committee on the Budget

DR. LEVY: The Budget Committee wishes to report and recommend the adoption of the following budget:

We anticipate again dues, $20,000; that with collection of rentals and the banquet tickets and dividends on our investments would give us total receipts of $34,967.

Our disbursements: Salaries, $12,852. The operation of the Journal, $3,000. The office expenses, $3,300. Travel expenses of $1,465. Our Annual Meeting, printing, the banquet, etcetera, of $2500. Various subscriptions to meetings and conferences, and so on, of $397, giving us what I might call a surplus or an amount unbudgeted for contingencies of $1628.

I would now like to present the budget.

Your Committee on Budget recommends adoption of the following budget for the year 1961:

RECEIPTS			
Dues—State Society		$20,000.00	
Dues—AMA		9,750.00	
Collection Commissions—AMA Dues		97.50	
Overhead Contribution from Medical Journal		1,980.00	
Exhibit Rental		1,000.00	
Banquet Tickets		1,400.00	
Dividends		740.00	
Total Receipts			$34,967.50
DISBURSEMENTS			
Salaries			
Salaries	$12,600		
Social Security Taxes	252		
			$12,852.00
Operations			
Journal Subscriptions		$ 1,300.00	
Audit		275.00	
Committee appropriations			
Medical Service and Public Relations	$ 500		
Public Laws	200		
AMEF	150		
National Defense	100		
Medicare Adjudication	50		
Woman's Auxiliary	100		
Contingency	400		
		$ 1,500.00	
			$ 3,075.00
Dues Forward			
American Medical Association			$ 9,750.00
Office			
Academy contribution	$ 2,100		
Telephone & Telegraph	550		
Stationery & Printing	500		
Miscellaneous	150		
			$ 3,300.00
Travel			
AMA—Delegate	$ 500		

AMA—MSEA Conference	165	
AMA—Public Relations Inst.	150	
Local	300	
Contingency	350	
		$ 1,465.00
Annual Meeting		
Stenotyping	$ 300	
Printing	200	
Supper—House of Delegates	200	
Banquet	1,200	
Guest Speakers	300	
Prospectus	50	
Freight Charges	100	
Wiring	50	
Porters	30	
Clerical Help	45	
Janitorial Help	25	
		$ 2,500.00
Subscriptions, Contributions, Dues		
AMA—Aces & Deuces Dues	$ 25.00	
Conference of Presidents of State Medical Societies	25.00	
Medical Society Executives Association	10.00	
Delaware State Chamber of Commerce	50.00	
Delaware State Science Fair	50.00	
Shearon Legislative Service	12.50	
Joint Council/ Aged	50.00	
Institute for Organization Management	175.00	
		$ 397.50
Unbudgeted for contingency	$ 1,628.00	

Some comment is in order concerning the 1961 budget. For the first time, we have included American Medical Association dues in our receipts, balancing them with an equivalent entry under disbursements. This has been done simply to bring the budget into closer accord with our books.

The Society has invariably lost money on its annual reception, banquet, and supper for the House of Delegates. Questioning the wisdom of subsidizing these affairs from the general fund, we have recommended pricing banquet tickets at $10 in 1961, in order that the reception and banquet may carry themselves.

Exhibit rental has been restored as an item in our receipts. Noting the return to a technical exhibit at the annual meeting this year, we assume that this will be permanent. The $1000 figure that we have estimated is probably conservative.

We call your attention to the overhead contribution from the Delaware Medical Journal. This represents a $1000 contribution toward the expense of maintaining the headquarters office, $480 toward secretarial service for the Journal, and $500 for the services of the executive secretary as business manager for the Journal. This amount will be passed on to the executive secretary as an increase in salary. The Society is matching the amount.

The contribution to the Delaware Academy of Medicine has been increased by $100, to cover the electricity used by electric office machinery and air-conditioners. This was part of our original occupancy agreement, and the Academy has now had enough experience to allow a building management expert to calculate the additional cost.

The projected cost of the annual meeting has increased considerably over last year. Some of this increase is due to additional expense made necessary by the technical exhibits, but this is expense which will be more than compensated by the revenue from those exhibits. The other portion of the increase has come from a transfer of the allowance for guest speakers from the travel fund to the annual meeting fund, where it properly belongs.

The Committee on Budget calls your attention to three contingency funds within the budget. One is for travel, one is for committee expense, and the other is uncommitted. Since it is impossible for us to anticipate exactly what the Society will be called upon to do in each of its many areas of activities within the next year and a half, we consider the keeping of uncommitted funds in the budget absolutely necessary. This budget, therefor, does not show exactly where all of the Society's funds will be spent during the next year, but instead gives a general idea of the proportions and the problems that we expect to meet. To budget in any other way would impose such rigid restrictions that the flexibility the Society must have, would be lost, and the organization crippled as a result.

Respectfully submitted,
Charles Levy, M.D., Chairman
R.L. Klingel, M.D.
T. H. Pennock, M.D.
W. C. Pritchard, M.D.
M. A. Tarumianz, M.D.

The report was accepted.

PRESIDENT MARVIL: We will now hear the report on Medical Education by Dr. Heckler.

Report of Committee on Medical Education

The Committee on Medical Education has directed its activity to two projects during this past year.

1. *Weekly Radio Seminars*:

In October of 1959, a series of 30 weekly radio programs was begun and carried out through April of 1960. The programs originated from a central Philadelphia FM station and were transmitted to 10 Delaware stations, of which 5 (Delaware Academy of Medicine, Wilmington, Delaware—Lewes, Delaware—Dover, Delaware—Seaford, Delaware and Milford, Delaware) were equipped with transmitter sets permitting return conversation to Philadelphia. Physicians who were unable to attend the meetings at the central locations could also receive through conventional FM radio.

The before and after examination in which 101 Delaware physicians participated gave this project as thorough an evaluation as we have ever known. The results, which will be reported tomorrow by Dr. Richardson, and the attendance records from this past year indicated that this was a fairly successful means of medical education and plans are now being made to resume the programs in October of 1960. The list of weekly subjects to be dis-

cussed will be published in the Delaware Medical Journal.

2. *Trans-Atlantic Clinical Pathological Conference*:

On April 20, 1960, the first trans-Atlantic broadcast between the Medical Society of Delaware and the Royal Society of Medicine, London, England, was carried out. This pogram was sponsored by Smith, Kline & French Laboratories, and consisted of a panel of 4 English physicians and 5 Delaware physicians. The two panels exchanged unknown cases for diagnosis and following each panels' discussion of the case, the diagnoses were revealed and discussed. Tape recordings of this program are available.

Respectfully submitted,
G. Barrett Heckler, M.D., Chairman
Albert Gelb, M.D.
Laurence L. Fitchett, M.D.

The report was accepted.

PRESIDENT MARVIL: the next report will be that of the Program Committee, Dr. Metzger.

DR. METZGER: The current program of the Medical Society beginning tonight will serve as our report.

I express my appreciation to you, Mr. President, to Dr. Rollins, Dr. Beebe and to Mr. Morris and to many other people who have helped to get this going this year.

This program was published in the Journal of the Medical Society of Delaware.

PRESIDENT MARVIL: Thank you very much. We will all see how the program ends, but I think it is a very good program—it certainly appears to be so.

The next report is on publications which will be in two parts. The first part is by Dr. Clagett.

DR. CLAGETT: I would like to take this opportunity to again stress with you that this is your Journal. The State Journal, Delaware State Journal, or any State Journal, in 1930 was a publication for the specific purpose of recording the business transactions at such a meeting as we have tonight and publishing the papers presented at the Annual Meeting of the Society. In 1960 a State Journal must be much more than that. We can not get the papers from our speakers because they will not come and speak to us if we demand, as is in our by-laws, that they submit a manuscript. So many times we have to go without those papers.

This is your Journal. It is my conviction that this is a Journal where we as members of the Society should exchange ideas, ideas that are not at all breathtaking. We are not trying to compete with the big medical journals in the country; we are trying to establish a new department of briefcase reports. We have a professional writer in our department, and if you send us the notes that you have taken on a patient, with any appropriate X-rays or other data, we will work it up and get it started in this new department. But this is your Journal, and whether it continues to grow or whether it ceases to survive is up to you.

Report of the Publications Committee

Report of the Editor

The editor is pleased to report an increase in the amount of scientific material submitted for publication as compared with previous years. We plan to go ahead in our campaign to secure a greater volume of material, emphasis being placed upon case reports from members of the Society. We are continuing to solicit this material.

We have received numerous letters and verbal compliments regarding the improved format of the Journal. This obvious improvement is due entirely to the efforts of our Assistant Editor, Mrs. Melita Phillips.

A new schedule changing the assigned months of certain hospitals for their issue of the Journal has been issued. Further changes are expected. This is part of a program to achieve a better balance between the amount of text and advertising in certain months. The proposed changes will be of benefit to our sponsors which in turn will benefit us.

The editor deeply appreciates the constant interest and helpfulness of the members of the Publications Committee and the work done by the Business Manager and the Assistant Editor to whom any credit belongs for the marked improvement in the calibre of our Journal.

Respectfully submitted,
A. Henry Clagett, Jr., M.D., Editor

The report was accepted.

PRESIDENT MARVIL: Thank you very much, Dr. Clagett. I certainly agree with what Dr. Clagett has said. I think the Journal has certainly improved this year—I have heard a great many comments, both as to the appearance of it and the material in the Journal.

DR. MC GEE: Mr. President, I move a vote of appreciation for Dr. Clagett and his staff for what they have done for the Journal.
The motion was seconded and carried.

PRESIDENT MARVIL: We will now have the Financial Report on publications.

Report of the Managing Editor And Business Manager

Conclusion of operations, July,1959 issue through Conclusion of operations, July, 1960 issue

Statement A — Operating (checking) Account

	1958-59	1959-60
Balance, beginning of year	$ 9,526.36	$12,802.67
RECEIPTS		
Advertising	27,474.98	29,854.75
Subscriptions	1,332.04	1,321.50
SMJAB — Working Fund Rebate	1,008.65	809.60
SMJAB — Refunded Discounts	23.47	34.42
Reimbursed expense	8.50	445.60
Interest	87.50	87.50
Royalties		1.04
Single Copies	209.50	51.31
Rosters	24.00	20.00
Rebate on mailing permit	10.00	
Operating Total	$30.178.64	$32,625.72
Transfer from Wilmington Trust Co., Savings Account		1,849.17

Total	$30,178.64	$34,474.89
DISBURSEMENTS		
Printing and Mailing of Journal	19,888.74	23,080.40
Salaries	4,290.00	6,380.00
OASDI Taxes	92.40	167.50
Stationary and supplies	538.19	249.97
Copyrights	48.00	48.00
Manuscript Typing		42.50
Addressing of Journal	120.00	120.00
Cover Redesign		154.50
Plates		466.89
Press Clipping Service		200.00
Photography		107.41
Special Printing	175.00	133.75
Reimbursed taxes, MSD		303.95
Furniture		97.99
Travel and expense, including SMJAB reimbursed expense	270.95	332.09
Insurance	92.85	92.85
Recruitment	43.20	
Rights	80.00	
Credit Investigation	3.00	
Mailing Permit Transfer	10.00	
Rent, including prepaid rent	1,250.00	750.00
Operating Total	$26,902.33	$32,727.80
Transfer to Wilmington Savings Fund Society—Savings Account		5,000.00
Total		$37,727.80
Balance, end of year	$12,802.67	$ 9,549.76

Statement B — Savings Account

Wilmington Savings Fund Society		
Balance, beginning of year	$ 3,744.37	$ 3,875.41
Interest	131.04	135.63
Deposited		5,000.00
Balance, end of year	3,875.41	9,011.04
Wilmington Trust Company		
Balance, beginning of year	1,765.54	1,801.20
Interest	35.66	47.97
Transferred to Wilmington Savings Fund Society		1,849.17
Balance (account closed)	1,801.20	
Total in Savings Accounts	$ 5,676.61	$ 9,011.04

Statement C — War Bands

Purchase date — 1942	$ 3,502.38	
Cost		
Current Value		$ 3,502.38
Operating Funds and Reserve, beginning of year	$18,538.65	$21,981.66
Operating Funds and Reserve, end of year	21,981.66	22,063.18
Net Gain for Year	3,824.06	81.52

Respectfully submitted,
M. A. Tarumianz, M.D., Managing Editor
Lawrence C. Morris, Jr., Business Manager

The report was accepted.

PRESIDENT MARVIL: The report of Public Laws will be heard next.

Report of the Committee on Public Laws

(1) *Relations between medicine and optometry.*

During the past year, there have been no developments in this category. No legislation has been submitted by optometry in this state affecting the practice of medicine, and no steps have been taken by organized medicine to kindle the fires of controversy which have in the past burned in this area. Thus a relative truce exists and it is hoped that with continued sensible cooperation this situation will prevail. In connection with this, we call your attention to paragraph 6 of this report, which reinforces our hope that organized medicine and organized optometry in Delaware may be reaching a basis for amicable settlement of our differences.

(2) *Revision of the Medical Practice Act.*

The president judge of the Superior Court of Delaware, Charles L. Terry, Jr., appointed a committee to study proposals for revision of the Medical Practice Act. This committee included representatives of the Medical Council itself, the Board of Medical Examiners, and the Medical Society of Delaware. After a number of meetings of this entire committee, together with meetings of subcommittees, an act was prepared to amend chapter 17, title 24, Delaware Code, relating to medicine, surgery, and osteopathy. The amendment as finally created by this committee was passed by the legislature during the past year. The revisions in this amendment were chiefly in two fields: *One,* updating the requirements for licensure particularly in reference to foreign medical graduates in keeping with the recommendations of the Educational Council for Foreign Medical Graduates. *Second,* clarification of revocation or suspension of licensure and indeed creating a new category of suspension not previously in existence. This was supplemented by the creation of medical censor committees in each of the three counties.

(3) *The Medical Examiner system versus the Coroner System.*

Delaware lost its medical examiner by resignation as of December 31, 1959. The problem of obtaining another pathologist to fill the post of medical examiner was complicated by many factors, not the least of which was inadequate appropriations for the proper conduct of the office of the medical examiner. On the other hand, the request for additional appropriations for this purpose was complicated by the unwillingness of the legislature to provide such funds without the existence of a person to fill the post. It was felt by this committee that political realities in this state dictate the necessity of accepting the coroner system as a part of any workable solution to the problem of a medical examiner's existence here. This implies the development of means to improve the existing coroner system by incorporation of the services therein of a forensic pathologist. We have so recommended to the Attorney General. Meanwhile, the committee recommended to the Council of the Medical Society that it sponsor a bill to provide for supplemental appropriations for the medical examiner's office, and another which provided authorization for the state Board of Post-Mortem Examiners to engage a pathologist to do autopsies in the absence of an official state medical examiner. This was done, but it proved impossible to get passage of these bills in the absence of a physician in the medical examiner's office. The problem was ultimately resolved by appropriations from the Levy Courts of the three counties to engage physicians to work with the coroners in specific cases.

Complications have arisen in the handling of criminal cases requiring a decision of the medical examiner and enabling legislation has been secured to permit the office of the attorney general to handle this type of situation until the post of medical examiner is filled again. The situation remains at this point in a state of relative confusion. An effort was made by this committee to interest the Board of Post-Mortem Examiners to influence

the platform committee of the state conventions of the two major political parties to include the recommendation for adequate appropriations for the conduct of the medical examiner's office. The impression was gained that the Board of Post-Mortem Examiners felt that nothing could be done until the new legislature meets in January when another effort presumably will be made to straighten out this situation.

(4) *An act to amend Chapter 5, Title 24, Delaware Code, relating to Chiropody.*

This amendment was submitted by the chiropodists to qualify them for payment under the Workmens Compensation Act. The Medical Society had no objection to the extent of this bill, since it did not in any way alter what a chiropodist is by law already permitted to do in the state of Delaware. The original bill contained certain wording which stated that a chiropodist "shall be deemed to be a physician for this purpose". A substitute bill removing this implication was accepted by the chiropodists and has been submitted to the legislature. At the time this report was written, the bill was still pending.

(5) *Senate Bill 271*

The committee voted to give backing to Senate Bill 271 which provided a supplementary appropriation to the state Board of Medical Examiners. This bill passed both houses and was approved by the Governor.

(6) *Associated Reading Clinc*

An Associated Reading Clinc was opened in this area, directed by a chiropractor and an optometrist. The announcing literature did not specify the field of endeavor of each of these persons but only referred to them as doctors. The attorney of the medical society submitted the opinion that the directors of this clinic were violating the Medical Practice Act by presenting themselves as "doctors" without specification of the degree held. The problem was approached by a consultation with the optometric and chiropractic associations, both of which agreed that this was a circumstance which could best be straightenedout by each of the controlling societies in question, and promised to do so.

(7) *The Medical Care of the Aged.*

Since the last report, this committee has continued to be active in this field, and during the past year this activity has included the following:

(a) participation in the AMA regional conference on aging in Baltimore in March.
(b) participation in the Governor's conference on aging held in June in Smyrna.
(c) journey to Washington to confer with Senators Frear and Williams to emphasize our point of view in reference to federal legislation on this subject.

In these and other approaches the committee has attempted to express the opinion of the Society that the problem of the medical care of the aged has been grossly exaggerated for political reasons. It has repeatedly urged that no federal legislation be enacted at least until the subject has been thoroughly aired at the White House Conference on Aging in January 1951. It has recognized, however, the political realities of an election year and has urged our two senators to support only that federal legislation which recognizes that:

(1) the system be voluntary
(2) the system exist as far as possible outside the Social Security System
(3) the administration and determination of need be on a state level
(4) the system apply only to the indigent or medically indigent rather than all of the aged.

At the writing of this report it should be stated that both of our senators have supported this type of legislation in the Senate Finance Committee and are seeking to prevent dilution of this type of proposal by Forand-type legislation on the Senate floor.

(8) *The Physician as a Citizen*

The Committee has attempted throughout the year to awaken the physician to his responsibility as a citizen. This has been done largely through appropriate comments at various times at county society meetings. The successful outcome of the efforts by organized medicine and like-minded groups to constructively shape the manner and extent of the Congress' aid to older people has forcefully demonstrated the affect we can have on functioning as citizens.

An intensive two-day trip around Delaware by Mr. Reichmann of the AMA Forand Task Force and by our executive secretary was helpful, we think, in crystalizing opposition to the Forand approach among other organizations. The point must be made here that the Forand victory, while encouraging and important, was neither final nor the victory of medicine alone. We were ably supported by such divergent groups as the American Hospital Association, the Chamber of Commerce, the American Farm Bureau, and many others.

We can help consolidate our gains and further our opportunities to shape legislative policy at all levels of government in two definite ways:

First, realize that we do not stand alone. We have allies and we have opponents. Help that you can offer to allied groups, in or out of the health field, can be richly returned by their assistance in times of crises for medicine. The Committee feels that doctors who participate in community affairs, who hold office in service clubs, who join local Chambers of Commerce, who interest themselves in PTA's, who speak before various groups, contribute largely to the strength of organized medicine, as well as to their personal development.

Secondly, the Committee points out that laws arise from legislative climates, and that legislative climates depend upon who holds office. It is probably easier, and certainly the more intelligent approach, to elect the favorably-disposed candidate than to attempt to convert the ill-disposed. Partisan political activity is the only way to accomplish this. If physicians will exercise their rights and duties as citizens by informing themselves of the beliefs of the various candidates and by backing their convictions with legitimate influence and with campaign contributions, our legislative efforts will be vastly simplified and our results correspondingly greater. The Committee wishes to emphasize here that there are candidates friendly to medicine's position in each party, and that it is vitally important for doctors as voters to screen the beliefs of each candidate when making a decision.

Respectfully submitted
W. O. LaMotte, Jr., M.D., Chairman
G. A. Beatty, M.D.

J. Beebe, Jr., M.D.
J. L. Fox, M.D.
J. S. McDaniel, M.D

The report was accepted.

PRESIDENT MARVIL: The next report on the agenda is the Woman's Auxiliary.

Report of the Woman's Auxiliary 1959-1960

Keeping ever in mind that our primary function is to be of service to the medical profession, the Woman's Auxiliary to the Medical Society of Delaware has attempted to carry out the program suggestions received from both the national and state sponsoring bodies. Emphasis has been placed upon legislation, A. M. E. F., and recruitment for paramedical careers.

The legislative chairmen of our country and state auxiliaries, as well as the presidents of those organizations, sent letters and telegrams to our Congressman and Senators regarding the Forand Bill. At one critical time of the Forand Bill struggle, fifty postal cards (distributed at an Auxiliary meeting) were written, collected and mailed to our Congressman. In addition, the county legislative chairmen made a survey of Delaware's care of the aged. This report has been given to the Medical Society of Delaware for use at its discretion. Other material given to the Society is the result of a preliminary survey of medical care provided for the indigent in our state. The work consisted of listing alphabetically all hospital clinics and their services by day and hour, and all medical-care aid offered by various philanthropic agencies. The compilation was made by the Community Service chairman, and at the request of the Council of the Medical Society of Delaware.

Contributions from the Woman's Auxiliary to the Medical Society of Delaware to A. M. E. F. totaled $895.45 for this year. Though this amount is a new high for the Auxiliary, it is short of the desired goal; and, unfortunately, it does not represent participation by every member. Rather, it is reflective of the persistent work of the various chairmen for A.M.E.F. and A.M.E.F. projects.

Recruitment for paramedical careers remains a major activity in the Auxiliary program. This year the Health Careers Committee, in screening a total of thirty-one applicants, selected sixteen persons to receive grants-in-aid totalling $4,950.00. Fourteen of this group entered schools of nursing, two began their studies as medical technologists. Of the total amount given for grants-in-aid, $1,400.00 (for five awards) comes from the Woman's Auxiliary to the Medical Society of Delaware. The remainder is from two service clubs: the Lions Club of Milford, with a contribution of $600.00, supports two awards; the Rotary Club of Wilmington, from a fund of $2,950.00, makes possible nine additional awards. The Zeta Chapter of Beta Sigma Phi Sorority of Wilmington also participates in the Auxiliary Health Careers program by giving a grant-in-aid every third year. The recipient of their next award is due to be named in 1961. Recently other organizations have requested information as to how they may cooperate with the Auxiliary program. Students currently benefiting from grants to the Health Careers program are in Beebe Hospital, Lewes; Delaware Hospital; Memorial Hospital; Milford Hospital; St. Francis Hospital; and Wilmington General Hospital of Medical Technology.

Though A. M. E. F., Legislation, and Health Careers may be highlights of an Auxiliary program, other committee work is not necessarily neglected. This fact may be brought to attention by the following:

ARCHIVES: Until this year, Auxiliary records have had no permanent home. They have been well kept, housed in more recent years in a steel filing case which has been shuttled from one President's home to the next. In the Fall of 1959, when the new addition to the Academy of Medicine building was completed, space became available for Auxiliary meetings and for the keeping of all Auxiliary records and supplies. The present project is a search for records of early years in order to complete the files.

CIVIL DEFENSE; MENTAL HEALTH; SAFETY: Activities in these fields are exceedingly well organized in Delaware. Such proficiency is demonstrated in all three areas at city, county and state levels that Auxiliary chairmen of such committees have questioned at times whether they are filling a real need in programming. This year, the Chairmen of Civil Defense, of Mental Health, and of Safety have maintained a liaison with their related civic organizations, worked under their direction, and kept files of their activities.

MEMBERSHIP: The goal of 100 percent membership has not yet been reached except in one county. Kent County, though the smallest of the Auxiliaries in Delaware, has achieved this distinction. Kent County also leads in the per capita donations to A. M. E. F. New Castle County, with the greatest concentration of practicing physicians in Delaware, has the largest Auxiliary membership but falls below the 100 percent mark. Sussex County, with problems pursuant to most resort areas, has an active membership of thirty-six.

Cooperation of the county auxiliaries with the state organization has been most gratifying in our efforts to promote Auxiliary work with, and for, the Medical Society of Delaware and American Medical Association.

Mary Virginia McGee (Mrs. Lemuel C.)
President

The report was accepted.

PRESIDENT MARVIL: Now we go to the Special Committees, and the first one is the Advisory Committee of the Woman's Auxiliary.

Report of the Advisory Committee of the Woman's Auxiliary

During the past year the Auxiliary has accomplished the following:

1. Prepared a fourteen-page list of facilities in Delaware available to and participating in the medical care of indigent patients. This report was given to the Society's Committee on Medical Services and Public Relations, A. J. Morris, M.D., Chairman, for review and recommendations as to disposition or distribution.

2. Listed New Castle County's existing facilities and services for older citizens, which report has been referred to the Society's Committee on Aging, C. J. Prickett, M.D., Chairman, for review and suggestions on implementation.

3. Urged examination of the implications of "Forand type" legislation followed by the mailing of letters from members of the Auxiliary to our

United States Senators and the Congressman from Delaware. (At one meeting of a county Auxiliary group fifty postal cards were signed and mailed. The President of the State Auxiliary sent both letters and a telegram on this subject in the name of Auxiliary.)

4. Requested the Council, Medical Society of Delaware, to approve subject matter and speakers which the Auxiliary may use in meeting requests for "programs" from lay groups.

5. The President of the Auxiliary has attended the following meetings related to the work of this group:

* Fall Conference for Presidents and Presidents-Elect of State Auxiliaries, Chicago, Illinois, 1959
* Pennsylvania State Conference Auxilary, 1959
* Maryland State Annual Meeting, Medical Auxiliary, Baltimore, 1959
* National Annual Meeting, Auxiliary, Atlantic City, New Jersey, 1959
* Fall Conference for Presidents and Presidents-Elect of State Auxiliaries, Chicago, Illinois, 1960
* Pennsylvania Conference Auxiliary, 1960
* Maryland State Annual Meeting, Medical Auxiliary, Baltimore, 1960
* New Jersey State Annual Meeting, Medical Auxiliary, Atlantic City, 1960
* National Annual Meeting, Auxiliary, Miami Beach, 1960

6. Utilized the following committees under stated objectives received from the Woman's Auxiliary of the American Medical Association: A.M.E.F., Archives, Bulletin Circulation, Civil Defense, Community Service, Finance, Hospitality, Legislation, Membership, Mental Health, Paramedical Careers, Press and Publicity, Program, Revision of Constitution and By-laws, Safety, and S.A.M.A.

Respectfully submitted,
Lemuel C. McGee, M.D., Chairman
C. C. Gray, M.D.
A. D. King, M.D.
R. F. Lewis, M.D.

The report was accepted.

PRESIDENT MARVIL: The next report is on Aging, Dr. Prickett.

Report of the Committee on Aging

Mr. President, Members of the House of Delegates, and Members of the Medical Society of Delaware The Committee on Aging is pleased to submit the following report for the year 1960:

The Committee benefited greatly by the panel discussions held at the 1959 meeting of the Medical Society of Delaware and by the studies made at the Governor's Conference on Aging in June, 1960.

Also, the Division of the Aging contributed much information through its report prepared for the White House Conference on Aging in January, 1961, and this information is available in detail in that office.

The population in Delaware in 1900 was approximately 184,000 with approximately 8,000 people 65 years of age. In 1940 with a population of 266,000, approximately 20,000 were over 65. In 1950 with a population of 318,000, 26,000 were over 65, while in 1960, with approximately 443,000, there were approximately 35,000 over the age of 65 or approximately 7.9% of the total population.

The Delaware State Employment Service reports that the older worker does not have a greater rate of unemployment than the young worker, but when he gets laid off, it is much more difficult for him to secure other employment.

The Social Security Division reports show that 24,194 persons received benefits or an increase over the previous year of 15%. The total payments to recipients in Delaware equals $1,573,076 per month.

As of June 30, 1959, 691 persons out of every 1000 in Delaware over the age of 65 received Social Security benefits, while the National average was 627.

In Delaware we have 10 General Hospitals, 1 for Tuberculosis, 2 for Mental Illness, and 2 for Chronic Illness. Licensed nursing homes number 36. The State Welfare Home has added a new building providing 196 beds. The Methodist Country House, under construction, will provide for 160 beds, and the Milton and Hattie Kutz Home now under construction, will provide accommodations for 40 beds.

Mortality in Delaware for those 60 years and over for heart disease comprised 55.68% of the total, neoplasms 15.62%, cerebral accidents 11.73%, with all other causes being below 3% each.

Out of a total of 504 disabled persons rehabilitated by the Delaware Vocational Rehabilitation Division for the fiscal year 1960, 147 were 45 years of age and older and of this group 23 or 16% were 65 years and older. Rehabilitative services to the aged include the Delaware Curative Workshop, the Opportunity Center, The Memorial Hospital, Wilmington General Hospital, Veterans Administration Hospital, and Emily P. Bissell Hospital in the Wilmington area, and the Milford Memorial Hospital in Milford.

Social Services include Old Age Assistance which averages $49.79 per month and 44 out of every 1000 Delawareans over 65 receive an old age grant. Approximately one-fourth of these recipients also received Social Security benefits which averaged $40 per month.

Delaware has 55,000 veterans and the VA program provided benefits for 1,470 Delawareans over the age of 65 in an amount exceeding $100,000 per month.

Railroad Retirement benefits were paid to approximately 1,940 persons residing in the State which amounted to $182,000 per month for those over 65.

Also, 574 retired State employees were receiving pensions.

Thirty-six social agencies are available to our older residents.

A low rent public housing project exclusively for elder citizens is being built by the Wilmington Housing Authority.

Delaware is greatly in need of the re-establishment of the Adult Education group.

Several towns in the State have Golden Age,

Senior Citizens, and other groups attractive to older people.

Biological research is being carried out in Dover and Wilmington hospitals.

The Division of the Aging will continue its studies following the White House Conference on Aging and this information will of course be available to old people, hospitals, physicians, etc.

The Governor's Conference on Aging recommended a central agency in the State to correlate, coordinate and integrate the facilities available in the communities so that maximum utilization could be effected;

That the State of Delaware inventory its existing facilities and the scope of the needs for their use;

That a committee or group be formed in the State which would keep abreast of reasearch being done in the field of Gerontology, the needs of research in the State and disseminate information concerning research needing to be done.

Respectfully submitted,
C. J. Prickett, M.D.,Chairman
Joseph A. Elliott, M.D.
Arthur J. Heather, M. D.
Harold J. Laggner, M.D.
Felix Mick, M.D.
R. B. Thomas, M.D.
Arthur Tormet, M.D.

The report was accepted.

PRESIDENT MARVIL: We will now hear the report on the Special Committee for Alcoholism by Dr. Tarumianz.

Report of Committee on Alcoholism

One of the serious problems in Delaware is the extent of alcoholism which continues to exist in spite of the efforts toward prevention and rehabilitation being made by agencies and organizations, both professional and lay. Although complete data are not available, such information as was obtainable is evidence of the magnitude of the problem. Residential care and treatment of persons addicted to alcohol have been provided by four state-supported institutions. Rehabilitative services have been provided by one-state supported agency and at least two voluntary organizations. In addition, it must be recognized that numerous agencies such as the courts of the cities and State and state agencies like the State Board of Health and the State Department of Public Welfare undoubtedly are working with alcoholics at times and may help in the rehabilitative process while dealing with problems other than alcoholism in their clients.

Fortunately for those so afflicted, alcoholism is being recognized more and more as an illness. The general hospitals are demonstrating willingness to admit alcoholics in the acute stage as well as alcoholics suffering from psychosis associated with alcoholism. General practitioners also are using their skills and knowledge of the new medications now available to treat acutely ill alcoholics and to assist them to obtain treatment in the residential facilities. Formerly, psychiatrists in private practice were reluctant to accept alcoholics as patients because of the length of treatment usually necessary and the comparatively small percentage of success with this kind of patient. Recently the Delaware psychiatrists have been including among their patients selected individuals addicted to alcoholism. It has been reported that some success in treating alcoholism has been obtained with selected cases to whom Temposil has been administered under a physician's care.

The following information from the state-supported residential facilities gives some indication of the problem of alcoholism in Delaware. These figures would be considerably higher, without doubt, if information could be obtained concerning the number of persons suffering from chronic or acute alcoholism who never come to the attention of the institutions or agencies. These persons are no less disturbing factors in human relationships in families, in industry, in practically every conceivable area of life.

The Board of Corrections, State of Delaware. The records of the State Board of Corrections indicates that during the fiscal year, 1959-60, the total number of commitments in Delaware on the charge of Drunkenness was 2,018. The total number of commitments on the charge Driving Drunk (or under the influence of liquor) was 693. The number of commitments on the first charge is just one less than the number for the fiscal year 1958-59 (total 2,019). The decrease in the number of commitments on the second charge is considerably larger — 28.4% fewer commitments on the charge of Driving Drunk in 1959-60 than in 1958-59. (The total for the previous year on this latter charge was 968). This decrease may be due, at least in part, to the amendments in the laws regarding this offense. Altogether there were, in 1959-60, 2,711 commitments for alcoholism as the primary reason. Although definite statistics were not available, it is recognized that use of alcohol was a contributing factor in numerous cases which appeared in the records of the State Board of Corrections under other categories.

According to a report by the Delaware Safety Council[1] based on police reports "more than a third of the 98 drivers involved in fatal accidents on Delaware streets and highways in 1959 had been drinking . . . . "Thirty-five of the 98 drivers involved in 73 fatal accidents in 1959 had been drinking. Thirteen of these were listed by the investigating officer as "obviously drunk." Fifteen others were considered sufficiently under the influence of liquor as to be impaired in their ability to function normally.

Among the 83 persons who lost their lives in traffic fatalities in 1959 in Delaware were thirteen pedestrians. Four of the pedestrians killed had been drinking.

The State Welfare Home And Hospital For The Cronically Ill. During 1959-60 25 patients (22 male, 3 female) admitted to the State Welfare Home and Hospital For The Chronically Ill were diagnosed as alcoholic. They ranged in age from 39 to 82 years. Five of these patients (4 male, 1 female) were discharged. One male expired.

The Delaware State Hospital. Among the patients admitted to the Delaware State Hospital during the fiscal year, 1959-60, with no previous admission to a psychiatric hospital, were 55 (44 male, 11 female) diagnosed as alcoholics with psychosis. Sixteen of these patients (14 male, 2 female) were readmitted. The age range of the patients admitted for the first time was 26 to 65 plus years for men, 26 to 65 years for women,

1"Drinkers Top Cause of '59 Fatal Crashes, List Shows," Wilmington Morning News, January 14, 1960.

with the average of 45.7 years for men, 43.4 years for women. Twenty-three males of this group (54.4 per cent) were between 36 and 50 years of age. Six of the women (54.5 per cent) were between 41 and 50 years old. The age range of the male patients readmitted was 26 to 65 years, rather evenly distributed through the decades. The average age for readmitted males was approximately 46.6 years. The two females were between 36 and 45 years of age.

Among the alcoholic patients admitted for the first time, there were six deaths, all male. Delirium Tremens caused the death of one patient three days after admission. Three died from heart failure, one death occurring seventeen days after admission. Cancer was the cause of death in one; cerebral hemorrhage the cause in the other.

At the end of the fiscal year a total of 71 patients (57 male, 14 female) with alcoholism as the primary diagnosis remained in the Hospital. The age range of the patients remaining was from 21 years (one male) to 65 plus years. Eight of the patients remaining were under 36 years of age. Thirty-seven (52 per cent) were between 41 and 55 years of age.

The Governor Bacon Health Center. For nearly twelve years the Governor Bacon Health Center has provided residential care and treatment for alcoholic men and women without frank psychosis. During the fiscal year, 1959-60, 84 alcoholic patients (70 male, 14 female) who had no previous record of residential treatment in a psychiatric hospital, were admitted to the Alcoholic Rehabilitation Unit of the Health Center. Twenty others (19 male, 1 female) were admitted for the first time to the Governor Bacon Health Center but previously had been patients in another psychiatric hospital. A total of 102 alcoholic patients were treated at the Health Center for the first time in 1959-60.

During the year there were also 82 alcoholic patients 74 male, 8 female) readmitted for treatment of their alcoholism. The total number of alcoholic patients admitted in 1959-60 for the first time or readmitted was 196 (163 male, 33 female).

The age range for the patients admitted for the first time was 20 to 74 years for males, 20 to 59 for females. The average age for male first admissions was 44.4 years; the average age for female first admissions was 41 years. The age range for readmitted males was 20 to 74 years, while the age range for readmitted females was 30 to 59 years. The average for readmitted males was 46.7 years, for readmitted females was 44.5 years.

At the beginning of the fiscal year (July 1, 1959), 39 alcoholic patients (33 male, 6 female) remained in residential care. There were, therefore, 225 alcoholics (196 male, 29 female) who received treatment in the Alcoholic Rehabilitation Unit of the Governor Bacon Health Center in 1959-60.

During the year 89 alcoholic patients (75 male, 14 female) were discharged from their first admission to a psychiatric hospital. Of the readmitted patients there were 107 alcoholics discharged (96 male, 11 female). One alcoholic male who had been readmitted to the Health Center was transferred to the Delaware State Hosepital for treatment of his psychotic condition. Altogether there were 197 discharges during the year (172 male, 25 female). Of this number 146 or 74 per cent were improved, while 51 or 26 per cent were unimproved on discharge.

Five alcoholic patients (all males) died at the Health Center during the fiscal year. Three had been admitted for the first time; 2 had been readmitted. The ages of these patients were 49, 50, 70, 71, and 74 respectively. Chronic alcoholism was the direct cause of death in 3 of those who expired. One died from coronary thrombosis, the other from the bronchopneumonia due to general arteriosclerosis.

The Mental Hygiene Clinics. Each year a small number of patients with alcoholism as a primary diagnosis are admitted to the Mental Hygiene Clinics of the State and receive out-patient service. During 1959-60, 44 patients (28 male, 16 female) were admitted to the Mental Hygiene Clinics. Of this number 34 (25 male, 9 female) were patients in the New Castle County Clinic at Farnhurst, 5 (3 male, 2 female) at the Kent County Clinic at Dover, and 5 (all male) at the Sussex County Clinic at Stockley. Diagnostic services only were given to 23 patients (20 at the Farnhurst Clinic, 1 at the Dover Clinic, and 2 at the Stockley Clinic). Treatment was given to 21 patients (14 at Farnhurst, 4 at Dover, 3 at Stockley). During the year 24 alcoholic cases were closed (22 at the Farnhurst Clinic, including 17 male, 5 female, and 1 male each at the Dover and Stockley Clinics). At the close of the fiscal year the mental hygiene clinics had 20 alcoholic patients still on active status (12 at the Farnhurst Clinic and 4 each at the Dover and Stockley Clinics). The age range of the alcoholic patients serviced by the Mental Hygiene Clinics during the fiscal year was 18 to 65 years. There were two males in the 18-21 year group (1 in the Farnhurst Clinic and 1 in the Stockley Clinic). The average age for the clinic patients was approximately 38 years.

Voluntary Agencies. The work of voluntary groups in rehabilitating alcoholics is significant. The Alcoholics Anonymous, with active groups in various parts of the State, contributes considerably toward getting into residential treatment persons who are problem drinkers and also giving supportive treatment to the patients after they are discharged from the Hospital. The AA also works with the patients during their hospitalization. The Wilmington Groups meet with the alcoholic patients at the Governor Bacon Health Center twice a week and at the Delaware State Hospital once a week. A group from lower Delaware holds a monthly meeting at the Health Center. Members of the AA act as sponsors for alcoholics in residential treatment. The Salvation Army frequently has provided a first step toward rehabilitation for some alcoholic men after hospitalization. Living accommodations and work have been made available at the Men's Rehabilitation Center operated by the Salvation Army and at the Haven of Hope, another building operated by this organization.

The Prisoners Aid Society of Delaware has included among its clients persons who have been incarcerated for misdemeanors or offenses involving the use of liquor. No doubt some alcoholics have found shelter at the Prisoners Aid Society Residence in Wilmington.

Temporary relief for individual alcoholic patients has been obtained occasionally from the State Department of Public Welfare to provide for their basic needs until they can re-establish them-

selves in a job. Without such financial assistance a former patient may again seek solace in liquor despite the fact that this has been largely the cause of his being 'down and out."

Conclusion. Although there seems to be greater awareness of alcoholism as an illness and increasing facilities for rehabilitative efforts with alcoholics, the problem continues to be quite serious in Delaware. The need for concerted action in developing a widespread, aggressive preventive movement is apparent. All community agencies, both public and private, must assume responsibility for a strong program, especially one which will help to solve the basic problems with which the alcoholic is trying to deal or to escape through the excessive use of liquor. The resources of education, religion, science, medicine and social science must be mobilized to this end. It is important to rehabilitate alcoholics, but it is vastly more economical and of greater humanitarian value to prevent the enormous waste of human and material resources represented in alcoholism.

Respectfully submitted,
M. A. Tarumianz, M.D., Chairman
Bruce Barnes, M.D.
James A. Flaherty, M.D.
H. T. McGuire, M.D.

The report was accepted.

PRESIDENT MARVIL: The next report will be the American Medical Educational Foundation, Dr. Fox, Chairman.

AMEF Committee Report

Your AMEF Committee reports a total of $5,417.89 you have in contributions during the year of 1959 by Delaware physicians and your Woman's Auxiliary to the State Medical Society. The solicitation of physicians has been entirely by mail. All contributions have been purely voluntary rather than through assessments. Your Committee feels this is the most acceptable method of solicitation. We wish to make special mention of the work of the Woman's Auxiliary and its AMEF Committee, with Mrs. Richard W. Comegys as Chairman.

This Committee has worked hard, their efforts producing approximately 10% of the Delaware total. We wish to congratulate them and hope their work will continue in the future.

Respectfully submitted,
J. L. Fox, M.D., Chairman
F. R. Everett, M.D.
Virgil Hudson, M.D.
R. L. Klingel, M.D.
W. W. Lattomus, M.D.
C. G. Pierce, M.D.
G. O. Poole, M.D. (Deceased)
S. W. Rennie, M.D.

The report was accepted.

PRESIDENT MARVIL: The next is the Grievance Board.

Report of the Grievance Committee

I am happy to report that the Committee for Grievances of the Medical Society of Delaware, has had no complaints about our members referred to it during the past year, consequently, there has been no meeting of the committee.

Respectfully submitted,
Roger Murray, M.D., Chairman
L. L. Fitchett, M.D.
A. R. Shands, Jr., M.D.
H. V. P. Wilson, M.D.
E. R. Mayerberg, M.D. (Deceased)

The report was accepted.

PRESIDENT MARVIL: The next is Maternal and Infant Mortality, Dr. Hassler.

Report of Committee on Maternal and Fetal Mortality

During the year 1959 there were a total of 11,775 live births. There were six maternal deaths, giving a .53 maternal deaths per thousand deliveries. These six maternal deaths shall be designated as A, B, C, D, E and F.

Case A—Age 27, Gravida 1, 268 lbs. Patient died of irreversible shock and post caesarean sepsis. Delivery from below was impossible due to shoulder impaction. Some factors here, in retrospect perhaps are avoidable. Any patient of this weight certainly must be given credit for a share of the responsibility. Some factors are undetermined. The Schwartzman reaction could have played a part in this case.

Case B—Age 28, Gravida VII. This patient died at home while being attended by a midwife. There was an abnormal compound presentation and placenta previa. The specific cause of death undetermined. An autopsy suggested probable amniotic fluid embolus. This patient should have been hospitalized as soon as it was apparent to the midwife that the patient was in difficulty. Nothing could have been done for this patient by any physician in her home. All available forces were not marshalled in this case.

Case C—Age 42. Cause of death—Hemorrhage and shock. Rupture of ectopic pregnancy. This case might have been prevented had a diagnosis been made and immediate blood replacement and surgery resorted to.

Case D—Age 32. Cause of death—Acute pulmonary edema following patient's attempt to abort herself with a combination of turpentine and lysol solution. Autopsy showed chemical emboli throughout the lung fields. This case is 100% patient responsibility.

Case E—Age 27. Cause of death—Circulatory collapse-post surgical following supra-cervical hysterectomy following delivery from below. Clinical diagnosis of possible amniotic fluid embolism was suggested. No autopsy was obtained. All possible efforts failed to prevent this patient's ultimate demise.

Case F—Age 37, Gravida X, Para VIII. Cause of death—direct obstetric eclampsia. Patient had a B/P 240/140 when admitted to hospital and 4 plus albumin in a catherized urine specimen. This patient failed to respond to therapy during 5 days of hospitalization. The uterus should have been evacuated, however the period of gestation was only 30 weeks at best and the possibility of getting a viable baby would have been poor. This patient had been recommended for a tubal ligation prior to this last pregnancy. The hospital committee did not pass on this suggestion. This case has some avoidable aspects involving both professional and patient factors.

The deaths as they have occured in 1959 again show—hemorrhage, infection, toxemia and emboli phenomena as the leading causes of maternal death.

Therefore we must continue to be alert to the blood status of all patients. Early recognition of significant blood loss and prompt action to correct the situation must be taken.

The post delivery usage of intravenous pitocin in 5% glucose is very helpful in preventing post partum blood loss from the atonic uteri. This is extremely beneficial where the help situation prevents the most desirable post delivery observation.

Further the committee suggests that where midwives are still functioning, these women should be instructed to send the patient to the hospital quickly, in the event of any complicating situation. No hospital will refuse admission to any patient presenting an obstetrical emergency.

Toxemia is still a serious problem in pregnancy, but can be greatly reduced through increased efforts to improve pre-natal care.

In conclusion, always consider the possibility of ectopic pregnancy in any female exhibiting signs of shock with a surgical abdomen regardless of history given by the patient. Further, always seek the help of fellow physicians when any problem arises. A consultation can be a life saving measure.

Respectfully submitted,
F. S. Hassler, M.D., Chairman
Benjamin Burton, M.D.
W. P. Ellis, M.D.
K. L. Esterly, M.D.
L. L. Fitchett, M.D.
A. M. Gehret, M.D.
C. C. Gray, M.D
O. N. Stern, M.D.
R. O. Y. Warren, M.D.

Report on Infant Mortality

The Committee on Infant Mortality has studied the hebdomadal deaths, those occurring within the first seven days of life, during the year 1959. The plan for the coming years is to study all of the neonatal deaths, those occurring within the first twenty-eight days of life, and the data for 1960 is being collected on this basis.

Study Sources

The information on the infant deaths was provided by the physicians responsible for the care of the babies, using the regular report form. Members of the committee assisted by supplying the data for the deaths that were not reported by individual physicians. These statistics are listed in Tables I and II.

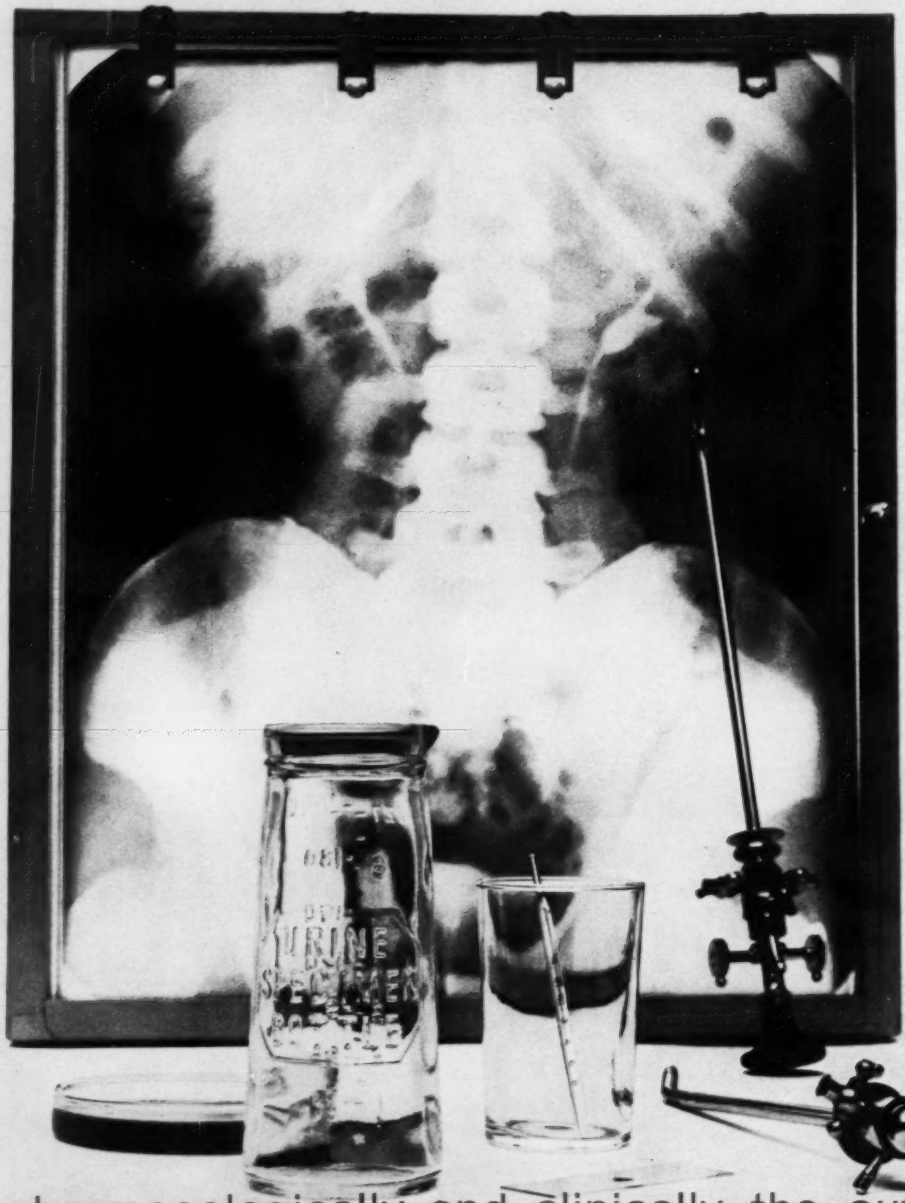
Discussion

The overall rates have not changed to any significant degree. The percentage of deaths due to any one cause has not varied much during the years that have been studied. However, it is worth noting that none of the deaths due to erythroblastosis during 1959 were considered preventable. In

TABLE I

	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Total live births	2543	2322	1958	831	204	1081	1034	397	477	732	196	11775
Deaths in 1st 7 da.	38	47	31	16	4	16	16	8	7	11	5	199
Corrected Deaths* in 1st 7 da.	37	45	31	16	4	16	14	7	7	11	11	199
Deaths/1000 L.B. in 1st 7 da.	14.5	19.4	15.8	19.2	19.6	14.8	13.5	17.6	14.7	15	55.2	16.9
Deaths/1000 L. B. in 1st 24 hr.	5.9	12.9	11.2	13.2	19.6	8.3	10.6	17.6	12.6	5.5	25.2	10.8
Deaths in 1st 7 da. wt. over 1000 Gm.	21	26	24	8	2	11	10	4	6	11	8	131
Deaths/1000 L. B. in 1st 7 da. wt. over 1000 Gm.	8.3	11.9	12.3	9.6	9.8	10.2	9.7	10.1	12.6	15	40.2	11.1
% deaths previable (500-1000 Gm.)	43.25	42.2	22.6	50	50	31.2	28.6	42 8	14.2	0	27.2	34.2
% deaths viable prematures 1000-2500 Gm.	43.25	48.9	61.3	37.5	25	37.6	64.3	28.6	57.2	63.6	36.4	48.2
% deaths full term	13.5	8.9	16.1	12.5	25	31.2	7.1	28.6	28.6	36.4	36.4	17.6
Inadequate prenatal care	7	11	3	1	0	3	5	2	3	1	6	42 (21.1%)

* Corrections: Delaware — Minus 1 delivered at home and taken to Del. Hosp.
Wilm. Gen — Minus 2 delivered at home and taken to W. G. H.
Milford — Minus 1 delivered enroute to Milford Hosp.
Minus 1 delivered at home and taken to Milford H.
Beebe — Minus 1 delivered in car on way to Beebe Hosp.



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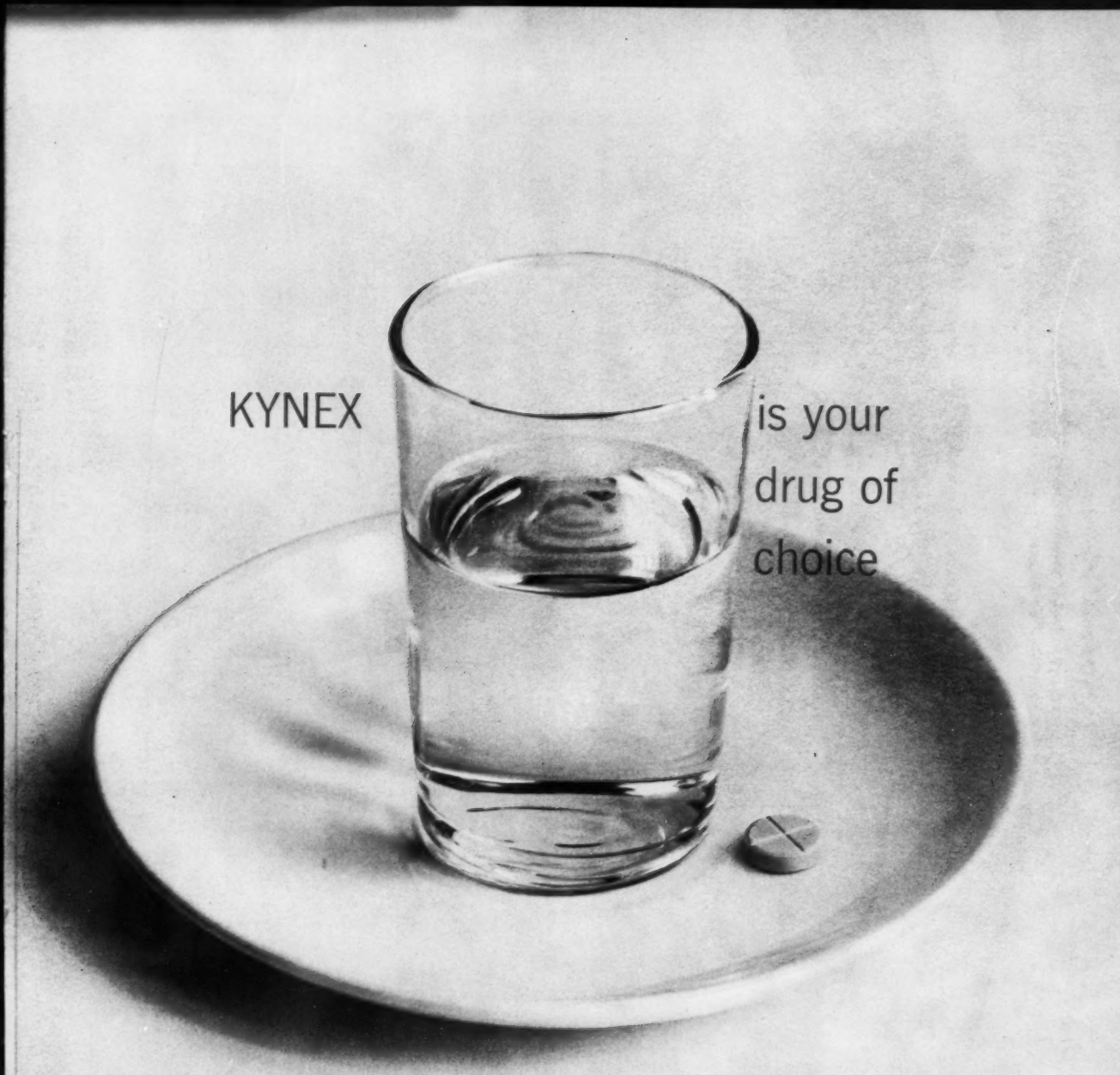
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed **TOTAL** side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

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NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

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TABLE II

Cause of Death	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total	
Undetermined	19	23	8	10	1	7	7	5	2	3	8	93	46.7%
Hyaline Membrane	3	6	7	1							1	18	9.0%
Congenital Anomalies	5		7	1		3	2		1	1		20	10.1%
Intrauterine Anoxia	6	5	5		3	1	1	1	3	3		28	14.1%
Intracranial Hemorrhage	2	7	1	1		2	2			3	1	19	9.5%
Intrauterine Pneumonia	2	1	1			1	1					6	3.1%
Meningitis			1									1	.5%
Sepsis			1									1	.5%
Erythroblastosis Fetalis		1		2						1		4	2.0%
Intrapulmonary Hemorrhage				1				1				2	1.0%
Bronchopneumonia		1							1		1	3	1.5%
Aspiration Pneumonia		1				2	1					4	2.0%
Total	37	45	31	16	4	16	14	7	7	11	11	199	
% Autopsies	52.7	53.3	58	37.5	25	75	68.8	50	41.9	81.6	0	107	53.8%
% Undetermined C.O.D.	51.4	53.2	25.8	62.5	25	43.7	56.3	62.5	28.6	27.2	72.6	46.7	

each of the previous years at least one of the deaths due to this cause was rated as preventable.

Obstetricians as well as pediatricians are, on the whole becoming more interested in establishing the proper cause of death in newborns. This is evidenced by a steady increase in the autopsy percentages from 39.2% in 1954 to 53.8% in 1959. The only hospital that has not shown improvement in this category is the Delaware Hospital, which ran 60-70% during the first three years of study, but only around 50% in the last three years.

Prenatal care has gradually improved over the past three years. In 1957, 28% of neonatal deaths had inadequate prenatal care. In 1958 this was reduced to 24% and in 1959, 21.1%.

Discussion of cases with preventable factors.

In spite of the fact that sedation of mothers in premature labor is frowned upon by most obstetrical authorities, it continues to be a very common practice in this state, and looked upon favorably by some of the obstetricians who are responsible for the training of residents.

There were two cases in which Cesarean Sections were done and not considered to have been indicated. Perhaps consultation would have prevented these deaths.

Two deaths were probably due to aspiration of feedings. Both were attributed to inadequate nursing care.

Case I. 4 lb. 7 oz. white male born of gravida V mother. Mother was Rh negative with no titer. Baby was delivered by elective Cesarean Section at 31-32 weeks gestation. The indication given was two previous deaths in utero at 7-7½ months gestation. However, with more careful scrutiny of the history it was found that this reasoning was not valid since the previous pregnancies resulted as follows:

1. 12 year old female—well.
2. 7½ months premature which lived 6 days—autopsy showed subdural hematoma.
3. Abortion at 2-3 months.
4. Fetal death in utero at 7½-8 months.

Baby's cord blood was Rh positive, Coombs test negative. Baby had respiratory distress from birth and autopsy showed hyaline membrane disease.

Case II. An inaccurate history of LMP by mother confused the time of elective Cesarean Section for cephalopelvic disproportion. Section was done two months early, at what was thought to be two weeks prior to EDC. A 2 lb. 8 oz. baby was delivered and died after 8 hrs. Autopsy showed only immaturity.

Case III. 4 lb. 8 oz. white male delivered spontaneously and in good cndition. Developed respiratory distress at the time of the first feeding. Feedings were continued in spite of this and the physician was not notified until after the condition worsened at the next feeding.

Case IV. 2 lb. 5¾ oz. Negro female. Aspirated gavage feedings twice. Autopsy showed aspiration pneumonia.

Case V. 7 lb.2 oz. Negro male delivered spontaneously (?). There was a shoulder arrest. Baby had intercranial hemorrhage. Obstetical consultation should have been obtained.

Case VI. Low forceps delivery of 6 lb. 6 oz. baby. Tear of the Tentorium Cerebelli. Entire right side of the occipital bone was raised. Respiratory distress followed by convulsions.

The committee wishes to again acknowledge our thanks to Mr. Lawrence Morris, Jr., Executive Secretary of the Medical Society of Delaware, The Delaware State Board of Health, and co-operation of all the physicians interested in improving maternal and infant care in Delaware.

The report was accepted.

Report of Committee on Medical Economics

The Committee on Medical Economics held two meetings during the year. The first meeting was well attended by members; the second lacked a quorum.

At the meeting of April 27, 1960, the increasing utilization rate experienced by Blue Cross and the lengthening average stay in hospitals of Blue Cross patients were discussed. The matter had been referred to the Committee by the House of Delegates for investigation and report at the September, 1960 meeting. Discussion of probable causes of these statistics set high the undertaking of more complicated surgical procedures in the state and the operations on so called "poor risk" patients. It was agreed by the Committee that there may be abuse of Blue Cross and Blue Shield, but that this is negiligible and by no means accounts for all increased expenditures. A member of the Committee will undertake to ask the Joint Hospital Council of New Castle County to analyze Blue-plan cases in the hospital over the past few years and present concrete information to the Committee.

The question of the desirability of instituting Blue Cross Group coverage for the members of the Medical Society of Delaware was favorably considered. The Executive Secretary is cooperating with the Committee on Medical Economics in writing this coverage which represents a twelve to twenty dollar saving to each member of the Society who elects to participate, rather than act individually.

The Executive Secretary and the Chairman of the Committee on Medical Economics represented this organization at a meeting of the American Medical Association Conference in Washington, D. C., on Relative Value Studies. The impact of the California Medical Association, which started Relative Value Studies in 1952, highlighted this conference. It is also noteworthy that the Committee of Medical Practice of the American Medical Association of which Dr. Lester D. Bixter is chairman has been working hard to help the profession catch up with patient-doctor relationship without third party or government interference.

After discussion, this Committee agreed that a Relative Value Schedule for Delaware would be desirable. As several states have already adopted a plan, the following recommendations were adopted for presentation to the Council:

A. That the Council adopt the principle of establishing a Relative Value Scale for this state.

B. That the Council consider converting the Medicare Schedule from dollar amounts to relative value units as a nucleus for the proposed Delaware Scale. It is noted that the Medicare Schedule was drawn over the California Medical Association Plan.

C. That the Council undertake to familiarize all Delaware doctors with Relative Value Studies and uses.

Respectfully submitted
E. L. Stambaugh, M.D., Chairman
William Cooper, M.D.
R. D. Sanders, M.D.
Walter H. Lee, M.D.
Ulo Ware, M.D.

The report was accepted.

Report of the Committee on a Medical School

To the Members of the House of Delegates of the Medical Society of Delaware.

In December, 1959, the Council of our society authorized the investigation of the need for and feasibility of a medical school for Delaware. Following a suggestion from Governor Boggs that our society should confer with the University of Delaware regarding the matter, the president, vice president and two others met in April with Dr. Perkins and several of his board of trustees.

Our committee and Dr. Perkins' committee had arrived at the same conclusion by previous independent studies. Briefly the findings were:

1. Present medical graduates (6860 annually) are too few for present needs and in ten years will be 30% below present physician-population ratio.
2. Foreign graduates who have been filling deficits will be sharply curtailed due to the Educational Council for Foreign Graduates restrictions.
3. There are 700-800 vacancies in third and fourth year United States medical school classes at present.
4. That a two year medical school in Delaware would be desirable especially since our state's population growth is so rapid and since Delaware is presently fifteen percent below the United States national average in physicians.
5. Dr. Perkins' estimate for cost is two million dollars for buildings and fourteen million dollars for annuities. He stated that a medical school would fit in well with the present graduate program.

This letter is being sent out in advance of our House of Delegates meeting so that each member may consider it and help in deciding the course our society should take. If action is favorable our society could help provide:

1. Teaching staff
2. Help in fund raising

There is considerable lay interest in such a project especially if research is connected with the medical school. Many believe that funds could be raised for such a project without great difficulty, with the help of some federal aid.

Respectfully submitted,
James E. Marvil, M.D., Chairman
L. B. Flinn, M.D.
A. M. Gehret, M.D.
L. C. McGee, M.D.
C. M. Moyer, M.D.
A. R. Shands, Jr., M.D.
H. V'P. Wilson, M.D.
Mr. Harry W. Lynch, Consultant

The report was accepted.

PRESIDENT MARVIL: The next report is on Medical Services and Public Relations.

Report of the Committee on Medical Services and Public Relations

The committee had three meetings during the year, in February, April and June.

Certain items of old business were either finished or continued:

1. The health information card, a project begun in 1959 with the help of the sister committee of the New Castle County Medical Society, was completed. Several thousand such cards were mailed to doctors throughout the state for distribution to their patients. The response has been rather quiet. No doubt some follow-up should soon be attempted to find out whether any of these cards have ever been used.

2. A health column for syndication in down-state newspapers has been incubating for over a year. Though this society abounds in gifted authors, they are a uniformly self-effecting group who have, thus far, been extremely reluctant to deliver, though not so reluctant to promise delivery. The committee makes progress slowly and is not discouraged.

3. The half-day conference for physicians about to enter practice which was reported upon one year ago, was discussed again. It was the decision of the committee that this project should be abandoned indefinitely.

4. The committee discussed, especially in its June meeting, the problems of enticing or encouraging suitable young men and women into the field of medical practice. Two suggestions were made:

a. That all schools in the state be reminded that this society is ready to provide "career-day" speakers provided reasonable notice is given. The schools are being contacted this month.

b. It might very well be desirable for this society to offer a scholarship to a young Delawarean in medical school, or contemplating medical school. A two-dollar annual assessment on every member would make a very useful fund. There are many aspects to this problem. It deserves study by all interested elements of this society.

Several items not previously discussed came before the committee.

1. Before the February meeting, President Marvil had asked this committee to look into a proposal made by Mr. Edgar Hare of the State Department of Welfare, and which had received considerable newspaper publicity. This was concerned with the purchase, by the state, of Blue Cross contracts for indigent residents of the state.

The chairman talked to Mr. Hare about this proposal. Mr. Hare had no knowledge of how many welfare patients were hospitalized each year, or whether the average hospital utilization by this group was greater than or less than that of the general population.

Accordingly, with the generous help of the administrative officers of the Delaware Hospital, and of Mrs. Donnelly of the State Medical Society, a study was done of all welfare patients hospitalized at the Delaware Hospital during the fiscal year 1958-59. The records of about five hundred people were studied.

Actual data are available in the office of this society. In general, however, it may be summarized here, as follows:

Welfare patients were hospitalized for slightly longer periods than the average private patient, for slightly shorter periods than the average ward patient. The average cost of each hospitalization was about $450.00 of which the New Castle County Levy Court paid approximately $45.00.

These figures formed the basis of a meeting attended by the chairman of this committee and the executive secretary of the society and the people at Group Hospital Service, and Mr. Hare.

It was felt that there were several reasons not to pursue this subject further at this time. These reasons were: 1) the shortage of money in the state legislature and 2) the uncertainty of what the national legislature might enact in the near future as part of a program to help the aged.

2. A Newsletter for lay friends of the society was discussed and a sample drawn up. A proposed mailing list was discussed.

3. Sample spot announcements for use on radio were prepared and discussed. The problems of a) whether we would be given time or would have to buy it; b) how, where and for how much could we have these recorded, are currently occupying the attention of the committee.

4. The desirability of contacting not only the traditional friends of organized medicine such as the chamber of Commerce, the N.A.M., but also of contacting less traditionally friendly groups such as organized labor was discussed at great length and tabled.

Respectfully submitted,

A. J. Morris, M.D., Chairman
J. B. Baker, M.D.
D. D. Burch, M.D.
R. R. Clayton, M. D.
A. E. Maresch, M D.
E. R. Mayerberg, M.D. (Deceased)
J. T. Metzger, M.D.

The report was accepted.

SECRETARY CANNON: The Council, after hearing this report, felt that an additional resolution would properly be part of this report, and it is submitted as part of this Committee's report as an addendum by the Council, particularly in view of certain legislation which has passed in Congress:

"That the State and Counties of Delaware should immediately appropriate matching funds to adequately care for the indigent in hospitals as provided by the Kerr amendment to the bill passed in Congress on the medical care of the indigent."

PRESIDENT MARVIL: We are now ready for a motion on the resolution.

A motion was made, seconded and carried to accept the resolution.

SECRETARY CANNON: Mr. Chairman, this report included the suggestion of a two dollar assessment and we suggested more. Should we take that up at this time?

PRESIDENT MARVIL: There is also another resolution attached to this report which we may consider separately at the present time.

SECRETARY CANNON: The Council, in discussing the suggestion in the report that a two dollar as-

sessment be used as a scholarship fund for Delawarians in Medical School, felt that this would be an adequate amount as there are many problems involved. Feeling that such a fund be highly desirable, the Council recommends to the House of Delegates that a resolution or motion be passed that each member be assessed five dollars a year to be used for this Medical Scholarship Fund, to be administered at the discretion of the Council.

If I may explain, there is much talk of a two-year medical school therefore the exact disposition of such a fund at this time could hardly be clearly defined. In order to start such a fund, we felt that the specific utilization could be deferred but that the fund could be built up by a five-dollar a year annual assessment for medical scholarships.

A motion was made, seconded and carried to assess each member five dollars a year for the Medical Scholarship Fund.

PRESIDENT MARVIL: We will now have six special committee reports.

Committee on Medicare Adjudication

No cases were referred to the Committee during the past year.

Respectfully submitted,
W. F. Preston, M.D., Chairman
J. R. Fox, M.D.
O. A. James, M.D.
E. N. Johnson, M.D.
S. W. Rennie M.D.
G. M. Van Valkenburgh, M.D.
Harold Wilberg, M.D.

The report was accepted.

Committee on Medico-Legal Affairs

The following is the Chairman's report on the activities of the Medico-Legal Affairs Committee of the Medical Society of Delaware.

1. The Chairman for the Bar and the Chairman for the Medical Society had a number of active conferences regarding plans for a meeting of the Joint Committee to be held in the Fall of this year.
2. A joint meeting of the committees was held at the Delaware Academy of Medicine, at which time positive suggestions were taken under consideration for the program for the Fall.
3. A meeting of the Joint Committee will be held during the month of August to select a date for the meeting and to complete plans for the program.

Respectfully submitted,
James T. Metzger, M.D., Chairman
W. L. Bailey, M.D.
James Beebe, Jr., M.D.
W. R. Campbell, M.D.
J. L. Fox, M.D.
P D. Gordy, M.D.
J. W. Howard, M.D.
R. F. Lewis, M.D.
J. S. McDaniel, Sr. M.D.
O. J. Pollak, M.D.
G. M. Van Valkenburgh, M.D.

The report was accepted.

Committee on Military and Veterans Affairs

As far as I know there has been no business for the Committee on Military and Veterans Affairs. Consequently there is no report to be submitted.

Respectfully submitted,
O. A. James, M.D., Chairman
R. L. Dicky, M.D.
G. A. Lessey, M.D.
J. W. Lynch, M.D.

The report was accepted.

Committee on National Defense

A report of this Committee was published in the June, 1960 issue of the Delaware Medical Journal. There is no further report.

Respectfully submitted,
J. R. Beck, M.D., Chairman
L. M. Dobson, M.D.
D. N. Gay, M.D.
J. B. Homan, M.D
D. N. Sills, Jr., M.D.
A. C. Smoot, Jr., M.D.

The report was accepted.

Committee on Polio Immunization

The Committee on Polio Immunization had one meeting this year; it was held in Dover in February and was poorly attended.

However, the name immunization program as in 1959 was put into effect. It was less well attended, but the success of immunization may be attested by the number of cases of Polio in Delaware.

Respectfully submitted,
H. H. Stroud, M.D. Chairman
R. H. Beckert, M.D.
George Boines, M.D.
M. I. Handy, M.D.
F. I. Hudson, M.D.
C. M. Moyer, M.D.
J. C. Rawlins, M.D.
R. O. Y. Warren, M.D.

The report was accepted.

The Committee on School Health

The Committee on School Health has had one formal meeting and subsequent work by several members of the committee with the following results:

1. It is recommended that each County Medical Society establish a committee on school health, and that such committees might encourage the development of school health councils in each school district.

2. It hoped to prod the presently inactive state School Health Council into activity.

These decisions were made on the basis that cooperative work of physicians, educators, and allied personnel interested in health problems was a proven method of accomplishing progress on both a state and local level. Since many school districts have problems that are locally different, the need for broad state planning and specific local organization at the school district level is apparent, thus. the desire to recommend both state and local health councils. The school health committee also agreed to cooperate with the Delaware Academy of Medicine in the presentation of a symposium on School Health on October 1, 9:15 a.m. to 12:45 p.m. at the Academy of Medicine. The proposed is as follows: Moderator, Dr. John Jenny, Director of Health, Physical and Safety Education in Delaware.

9:15 a.m. School Health Policy

a. William Bauer, M.D. of the AMA Headquarters will discuss the responsibility of the physician in the development of School Health Policies.

b. Mr. Thomas Mulrooney of the Wilmington Public Schools will talk on the Development of School Health Policy.

This will be followed by a discussion of invited participants and questions from the floor.

10:50 a.m. Intermission

11:00 a.m. Health Education in the schools

a. physician analysis incomplete

b. William Creswell, Jr., Assistant Executive Secretary of the AMA Association for Health, Physical Education, and Recreation, and Consultant in Health Education.

The School Health Committee also was interested in the development of meetings on athletic injuries to be held with the high school coaches, but unfortunately this has not made much progress because the coaches' organization appears to be defunct at present.

The Committee thought that its present activity should be one of encouraging interest in the above plans rather than attempt on its own to set up new plans and policies. It strongly urges that physicians have official connections with schools at various organizational levels, especially through the state and county societies and the proposed health councils, as well as personal contacts as parents and in local schools as examining physicians. It is hoped thus that physicians will assume responsibility for establishing good health policies through the recommendations of the AMA and NEA's joint committee on Health Problems in Education and its publication of "Suggestions of School Health Policies."

Respectfully submitted,
Robert W. Frelick, M.D. Chairman
S. Bishop, M.D.
J. A. Glick, M.D.
A. L. Heck, M.D.
J. C. Rawlins, M.D.

The report was accepted.

PRESIDENT MARVIL: Next are the reports of Delegates and the first one is A.M.A., Dr. McGuire.

DR. MCGUIRE: Mr. Chairman, gentlemen, members of the House: This is a rather long report; it has been prviously published in the Journal, (July issue) and it is available to those who care to look it up and review it.

I would like to suggest and ask that more of you attend he activities of the House of Delegates. The interim meeting will be in Washington, D.C. this year. The day of the meeting of the House of Delegates is usually on Tuesday. All resolutions are made, and any member is privileged to attend, any member is privileged to amend a resolution, offer a suggestion, criticize or debate or attempt to compromise any of these matters.

Many people are highly critical of the House and its actions and I think a lot of the criticism is based on ignorance and lack of information and knowledge, and I think it is incumbent upon all of us to be aware of how this organization works. I think it is democratic. I think they are as highly an opiniated group of physicians and politically oriented people as you will find anywhere, from one end of the country to the other, and I think that anybody who shows the interest will find it very profitable and stimulating.

I hope you will take the opportunity of attending the June meeting next year which is in New York, and it is convenient and easy to get to.

The report was accepted.

PRESIDENT MARVIL: The next two reports will be by Dr. Washburn.

Report of the Representative to the Delaware Academy of Medicine

As your representative to the Delaware Academy of Medicine I have to report as follows:

A. During the past fiscal year the buildings of the additional wing of the Academy have been completed and placed in service.

The Academy is occupied in part by offices of the Medical Society of Delaware and of the Editorial Staff of the Journal of our Society and represents now as never before the center of organized medicine, dentistry and the allied professions in Delaware.

In addition it provides space for the offices of the New Castle County Medical Society and an auditorium for meetings of that society as well as meetings of the dental, nursing and other allied groups.

B. The library has grown in importance to the community and state. A list of accessions to the library appears regularly in our State Medical Journal. The periodical library is designed to meet the requirements of the medical and dental professions. and various specialties.

C. With reference to community activities, we have discontinued the Wilmington Health Forums. In their place it is planned to have a health fair in Wilmington, possibly in the Spring of 1961 or 1962.

On the recommendation of the Committee on Meetings and Postgraduate Instruction and with the approval of the New Castle County Medical Society, the Executive Committee of the Academy approved a "Speaker's Bureau" for presentation of medical problems to lay organizations.

A symposium on school health will be held at the Academy on Saturday, October 1, 1960.

On Tuesday evening, October 18, 1960, a joint meeting will be held of the Academy, the Delaware Diabetes Association and the New Castle County Medical Society. The speaker will be Dr. Thaddeus Danowski of Pittsburgh. His subject will be diabetes. On Tuesday evening, November 29, 1960, Dr. Richard H. Overholt of Boston will deliver at the Academy the second annual lecture on "Diseases of the Chest".

A meeting of the Medical-Legal Conference will be held this fall on a date to be announced.

At a meeting held under the auspices of the Academy, the subject of improving the standards of health care in nursing homes was discussed. The suggestions of this group were officially referred to the Council of the Medical Society of Delaware and will be the subject of a separate report.

Respectfully submitted,
Victor D. Washburn, M.D.

The report was accepted.

Report of the Delaware Joint Council to Improve the Health Care of the Aged

In keeping with the policy of the American Medical Association, the Council of this Society at a stated meeting held May 12, 1960, authorized the participation of the Medical Society in a Joint Council to Improve the Health Care of the Aged.

The Joint Council includes representatives of the Association of Delaware Hospitals, the Delaware Association of Nursing Homes, the Delaware Nurses' Association, the Delaware State Dental Society and the Medical Society of Delaware.

The Council authorized the appointment as members of the Joint Council to Improve the Health Care of the Aged: Allston J. Morris, M.D. Lawrence C. Morris, Jr., Executive Secretary, and Victor D. Washburn, M.D.

The Joint Council held an organizational meeting on June 9, 1960 with representatives present from all organizations listed above. Temporary officers were elected and committees appointed.

A second meeting was held on July 7, 1960. By-Laws were adopted, and the following named persons were elected as officers:

Chairman — Victor D. Washburn, M.D.
Medical Society of Delaware
Vice-Chairman — Miss Alice J. Ulmer, RN
President of the Delaware
Nursing Home Association
Secretary — Mrs. Grace Weiss, RN
Delaware Nurses' Association
Treasurer — James J. Ficca, D.D.S.
Delaware Dental Society

The Objectives of the Council are as follows:

1. To cooperate with the National Joint Council to Improve the Health Care of the Aged.
2. To identify and analyze the health needs of the aged.
3. To appraise available health resources for the aged.
4. To foster effective methods of payment for the health care of the aged.
5. To develop community programs to foster the best possible health care for the aged, including the establishment of standards for accreditation of nursing homes.
6. To foster health education programs of and for the aged.
7. To inform the public of the facts related to health care of the aged.

The Joint Council has agreed that information should be obtained from other states or areas as to the manner in which they are attemping to solve or bring about an improvement in the health care of the aged.

For example, our Joint Council is studying methods for nursing home accreditation now in use in Western New York State and in a pilot plan which has been operating for a year in a single county near San Francisco. We hope to adapt to local conditions methods that have proven successful elsewhere, and to evolve a concrete plan for such accreditation, on a voluntary basis, in Delaware. While our activities will definitely not be limited to this project, we feel that we must establish a concrete program and history of accomplishment, and that this is a logical place to start.

In this connection, it seems likely that establishments of a separate corporation of or as a subsidiary to the Joint Council may become desirable, although there are no definite plans for this at the moment.

The Council has been financed largely through the office funds of the Medical Society. While the expense has not been great so far, the Council anticipates asking for small treasury grants from each member organization to provide it with working capital.

Summary

This is a summary of an interview that Dr. Washburn had in San Francisco, which was not recorded and is therefore subject to error. The interview was held with Mr. Robert L. Thomas, Assistant Executive Secretary of the California State Medical Association. The interview was held in the offices of that association in San Francisco on Monday, July 11, 1960.

The California Joint Council is composed of the following groups: California Association of Nursing Homes, (this title is my version—the correct title includes that of rest homes) California State Dental Association, Southern California Dental Association, the California Medical Association.

Inclusion of the California State Nurses Association was discussed but was deferred. The Joint Council was financed initially by contributions of $250 by each of the four participating groups.

Three different state agencies, in as many areas, have licensing jurisdiction over nursing homes, rest homes and homes or institutions for the care of the mentally ill.

The formation of the Joint Council and decision to form and incorporate a committee on accreditation came after innumerable meetings were held over a period of twelve months or so with governmental and private agencies concerned with the health care of the aged. The corporate structure was considered desirable from the standpoint of possible litigation.

A pilot accreditation plan has been in operation in a single county in California for about one year. The plan's actual survey or inspection is similar to that used by the Joint Commission on Hospital Accreditation.

The actual survey or inspection is made by physicians usually retired from the Armed Forces of the United States. These persons will be on salary. Each survey is to be paid for by the home concerned, the fee probably to be based upon the bed capacity. It is my understanding that the report of the surveying officer will be reviewed by a committee appointed by the county medical society.

A list of nursing and rest homes and their accreditation status in each county will be distributed to members of the medical profession in that area.

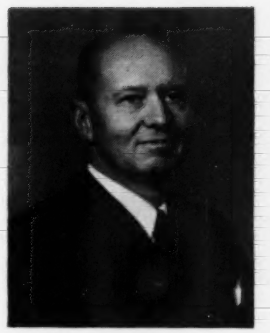
It is my impression that the approach to the problem in California was on the basis of sympathetic understanding and a desire to be helpful rather than that of stern and unyielding authority.

It is recommended that the House of Delegates authorize the participation of the Society in the incorporaiton of a committee of the Joint Council to Improve the Health Care of the Aged.

Respectfully submitted,
Victor D. Washburn, M.D.

The report was accepted.

The balance of this material will appear in the January issue.



President's Page

THE "HELPING" PROFESSIONS

"Religion, medicine, social work, psychology, and education are generally regarded as 'helping' professions . . . The absence of any genuine fellowship among the five groups constitutes a problem of much concern to both the groups and the public." (Cummins, L. Ross, The Helping Professions: An Intergroup Relations Problem, School and Society 80: 161-165).

There are techniques used in common by these professions. An example is "counseling." One may counsel with a religionist's slant, or with a biologic twist. or as a psychologic device (non-directive counseling) and so on, depending upon the training and basic assumptions of a particular counselor.

It seems apparent that the five professional groups should not persist in their isolation and lack of coordination. A tenet of medicine is that the welfare of the patient shall supercede all other considerations. Therefore, we must work toward maximal benefits for the recipient of the efforts of our own and other 'helping' professions. This goal calls for understanding and collaboration.

Our way of life is based on the premise that our citizens will participate in defining and answering community needs. The doctor by virtue of his education and daily experience has qualifications which make him capable of superior service in the planning and implementation of activities directed toward the improvement of his community. His assistance is needed because experence shows that such activities will be less effective without that assistance. If a physician feels that he is not qualified for such service and has nothing to offer to voluntary or official agencies in the field of social welfare, it is because he has not had a chance to learn of their problems and their similarity to some of the problems of medical care.

Long have we known of the impacts on health from poverty, poor housing, education, youth activities and recreation. Agencies working in these areas need the physician's support. One-third of the agencies in the United Community Fund of Northern Delaware employ nurses and utilize physicians in various capacities. Our channels of communication and support are found through service as medical advisors, board and society members, liaison representatives, volunteer workers, and purveyors of medical care. Civic and health aspects of community needs are closely interwoven.

Samuel C. McGee

In Brief

Heartbeats By Ear

Checking the patient's heart via his earlobe allows readings to be made while the patient is taking violent exercise, in contrast to standard techniques which require the patient to lie down, Dr. John S. laDue, associate professor of clinical medicine at Cornell told the Los Angeles Heart Association. The lobe acts as a filter, screening out the effects of muscle tensions and contractions, and permitting determination of what happens during severe stress periods.

Paraplegics Progress

There is hope that the 250,000 paraplegics in the U.S. may be able to walk with the aid of an electronic pack when experimental machinery is perfected. Successfully used on dogs paralyzed by anesthetics, the electronic system is operated by magnetic tape, which delivers little electric shocks to the four groups of leg muscles that carry out the walking motion.

Politics Obscure Benefits

Current political emphasis on socialized medical programs for the aged have obscured governmental benefits for the sick that the public does not know about. According to *Nation's Business*, "Federal benefits range from job help to tax privileges and from artificial limbs to mortgage insurance. The estimated cost of various programs ranges from $14 billion for retirement payments to $475 million for health care to $49 million for housing to $35 million for employment.

The Erstwhile Pro . . .

Cigarette smoking as a cause of lung cancer is questionable, says Joseph Berkson, M.D., staff member of the Mayo Clinic. Dr. Berkson said that there is some association between smoking and all causes of death. Cancer of the lung causes only a small fraction of the mortality rate and its increase may be due to the ever increasing life expectancy.

. . . And Con

Lung cancer could he reduced 80% if everyone stopped smoking, according to E. L. Wynder, M.D., staff member of New York's Memorial Center for Cancer and Allied Diseases. He claims that clinical records show the lung cancer death rate among persons smoking 40 or more cigarettes a day to be 217 per 100,000 compared to only 44 among non-smokers. He added that in the United States alone, 30,000 persons will die this year of lung cancer caused by smoking.

Coffee And/Or Exercise Breaks

Now that heavy labor and practically all bodily exercise have been eliminated from jobs, it has been suggested by heart specialist Herman K. Hellerstein of Cleveland that Americans take exercise breaks instead of coffee breaks to keep themselves physically fit.

While it has been known for some time that coffee contains niacin, a study made by four physicians has established that four cups of dark roast coffee provide an adequate daily intake of the essential vitamin. *Medical Science, April, 1960.*

Personal Glimpses

Robert W. Frelick, M.D., lectured on *Advances in Medical Uses in Radiation* before Beta Beta Beta, student biology society, University of Delaware . . . Hal W. Geyer, M.D., was guest speaker at a meeting of the Rehoboth Auxiliary to the Beebe Hospital . . . C. Leith Munson, M.D., led a discussion on the topic *Pre- and Postoperative Care of Surgical Patients* at the Workshop held by the Delaware Nurses' Association . . . Walter H. Comer, M.D., was the guest speaker at a meeting of the Delaware Association of Nurse Anesthetists . . . Lemuel C. McGee, M.D., was guest speaker at the dedication ceremony for the Jean Ellen duPont McConnell Nurses' Home, Beebe Hospital . . . Leonard P. Lang, M.D., gave the address at the "Careers in Nursing Day" in P. S. duPont High School, on *How an Allied Profession Looks at Nursing*" . . . At the 5th Annual Medico-Legal Seminar, sponsored by the Joint Committee on Medico-Legal Affairs of the Medical Society of Delaware and the Delaware Bar Association, James T. Metzger, M.D., Chairman of the Joint Committee, called the morning session to order; Lemuel C. McGee, M.D., made introductory remarks; Drs. S. Ward Cascells, Martin B. Pennington, Philip D. Gordy, and Paul A. Shaw participated in the discussion . . . Arthur J. Heather, M.D., addressed the Delaware Society for Crippled Children and Adults and showed color films of the mechanical hand which he developed under an Easter Seal Grant . . . Nathaniel Young, M.D., spoke on "Tuberculosis" at a meeting of the Delaware Society of X-ray Technicians . . .

New Posts

Floyd I. Hudson, M.D., was elected to a three-year term on the executive committee of the Association of State and Territorial Health Officers . . . Mark Kenyon, Ph.D., formerly Director of the State Board of Health's program for prevention of crippling, will take up his new duties in December as Executive Director of Nassau County Medical Society and Nassau County Academy of Medicine, Garden City, New York . . .

Leslie W. Whitney, M.D., announced two new scholarship awards made by the Delaware Division of the American Cancer Society to students at the University of Delaware majoring in biological sciences . . . Joseph A. Arminio, M.D., president of the New Castle County unit of the American Cancer Society, presented certificates of merit to groups of women of four Wilmington churches for hours of service to home patients and addressed the group on the subject of *Cancer Detection Examinations and the Value of Check-ups* . . .
Gerald A. Beatty, M.D., launched the 1960 Christmas Seal Campaign by presenting the new Christmas Seals, flown in by helicopter, to civic organizations in Newark, Wilmington and Dover . . .

Dental Discovery

A U.S. grant has been given Dr. Wiley J. Adams of Oklahoma City to develop his revolutionary idea that the sixteen back teeth cannot be made sharp enough with porcelain. They should be made of chrome cobalt, he says.

Auxiliary Affairs

A BIRTHDAY

This December the Woman's Auxiliary to the Medical Society of Delaware will blow out thirty-one candles on its birthday cake. On December 10, 1929 the first meeting was held at the Wilmington Country Club.

The idea was conceived by the members of the Medical Society of Delaware who wished to provide a Delaware sister for the other state auxiliaries. They passed a resolution to this effect at their annual meeting at Farnhurst, Delaware in October, 1929. Mrs. Harold Springer, Chairman, Mrs. George McElfatrick, and Mrs. William O. LaMotte were appointed a committee to make plans for the auxiliary.

The doctors sponsored a lovely card party and tea for their wives at the Diamond State Tea House on October 11, 1929. Mrs. Springer and Mrs. LaMotte were the hostesses, assisted by Mesdames T. H. Davis, M. A. Tarumianz, John Mullin, Paul Smith, and George McElfatrick. Each one at this delightful party agreed to attend an organization meeting in December.

That first official meeting was attended by twenty-two doctors' wives. Mrs. Springer presided and Mrs. LaMotte was secretary pro tem. The group unaminously elected Mrs. Robert Tomlinson, Wilmington, President; Mrs. Joseph McDaniels, Dover, 1st Vice President; Mrs. William P. Orr, Lewes, 2nd Vice President; Mrs. Lawrence Jones, Wilmington, Secretary; Mrs. M. A. Tarumianz, Farnhurst, Treasurer. Also at this luncheon the group approved the name of the socity, discussed the aims of the auxiliary, membership restrictions, meetings, and dues. Mrs. Tomlinson appointed an organization committee: Mesdames W. O. LaMotte, D. Davidson, Willard Smith, Cecil Harbordt, Roscoe Elliott and G. C. McElfatrick, chairman. On February 4, 1930 this committee met at the home of Mrs. McElfatrick to prepare the by-laws.

The next meeting was held in Dover February 11, 1930. The By-Laws, composed of 10 articles ,were read and discussed at the luncheon. A copy of the By-Laws was mailed to each member of the Advisory Committee: Drs. R. H. Davies, Douglas Davidson, I. J. McCollum, R. Beebe, and C. A. Sargent.

At the following meeting, held May 13, 1930 at the Rehoboth Country Club, the By-Laws were given a second reading and approved. Mrs. Hunsberger, National President-elect was a guest at that meeting.

At the end of the first year, the membership was seventy; they had a delegate to the A.M.A. and a fine organization which has carried on since that time, and has been of valuable assistance to the doctors. The auxiliary has also contributed their members to the national organization. In 1934 Mrs. Tomlinson was elected National President and several other members have been on national committees.

The following ladies were present at that first meeting at the Wilmington Country Club on December 10, 1929: Mrs. Harold Springer, Mrs. W. O. LaMotte, Mrs. Joseph McDaniel, Mrs. Robert Tomlinson, Mrs. William Orr, Mrs. Lawrence Jones, Mrs. M. A. Tarumianz, Mrs. Douglas Davidson, Mrs. T. H. Davies, Mrs. I. J. McCollum, Mrs. R. Beebe, Mrs. J. Beebe, Mrs. Willard Smith, Mrs. Cecil Harbordt, Mrs. Roscoe Elliott, Mrs. Paul Smith, Mrs. John Mullin, Mrs. Ward Briggs, Mrs. James Butler, Mrs. Edwin Bird, Mrs. C. E. Wagner, and Mrs. G. C. McElfatrick.

Editorials

THE SIREN WAILS

It is of interest that New York City, in an effort to safeguard its interns, passed a regulation some years ago forbidding an ambulance from going through a red light. This is in keeping with the current recommendation of a joint committee of the American College of Surgeons, the American Association for the Surgery of Trauma, and the National Safety Council, that ambulances be regulated the same as other vehicles.

This JOURNAL has expressed its views on this subject in September, 1959 and in February, May, and June, 1960. In the Proceedings of the House of Delegates of the Medical Society of Delaware (in this issue) is a resolution, passed unanimously, that shows this Society to be in agreement with the recommendations of the above committee.

The next session of the State Legislature will have presented to it a bill to so-regulate ambulances in the State of Delaware. This bill deserves your active support.

THE ANNUAL MEETING

Under the guidance of President Marvil this Society had one of the most interesting programs ever presented at an Annual Meeting. The papers by Drs. Levinsky and Large from Temple University School of Medicine were enthusiastically received by the audience. Dr. Levinsky has kindly offered your editor to assist in working up the stenotypist's report into shape for publication. Several members of the audience asked specifically that this be done. Dr. Large's paper, equally well given and received, is not suitable for publication due to the fact that a large number of beautiful color slides was an integral portion of this presentation.

IF YOU DON'T, SOMEONE ELSE WILL

How often lately has someone said, "He is a wonderful doctor," asks a well-known editor.

Not often? Woodrow Wirsig,* editor of *Printer's Ink*, the weekly news magazine of advertising and marketing, finds there is a reason why fewer patients today say complimentary things about their medical care. The public, he asserts, is developing a strong resentment toward doctors. It seems to make little difference to them that the United States medical services are the best anywhere in the world.

Mr. Wirsig tells us that the physician's tarnished image in the minds of the public presents a threat and a challenge. Unless the doctors themselves find a way to meet this challenge, someone else will do it for them. He cautions that we must realize the nation's health has ceased to be the concern only of the individual citizen; now it is a matter of universal, and political, concern. Like it or not, health is regarded by many as the government's responsibility.

Mr. Wirsig's prescription: Medicine must keep up, change, and lead the way if it is to survive. Doctors must take the initiative in health care programs and come forward with any needed new plan. Doctors have the knowledge—they can do it—if they don't, someone else will.

Frankly, while this editor has offered constructive criticism in the past (*Give Them a Break*, January, 1959 and *Take Time to Explain*, December, 1959) he has been equally alert to call attention to those of our members whose actions have been over and above the call of duty (Dr. W. T. Chipman, May, 1958). It is possible that Delaware differs markedly from New York but, unlike Mr. Wirsig, we frequently hear of the good done by our members.

*Presented at Southern Medical Association-Merrell Medical Economic Symposium, St. Louis, November 3, 1960.

DELAWARE MEDICAL JOURNAL

VOLUME 32 — 1960

INDEX TO TITLES AND AUTHORS

Diet or Drugs?

In the long term control of serum cholesterol, dietary therapy can achieve the objective in the manner most closely approximating physiological norm.

The long term control of elevated serum cholesterol through changes in the dietary pattern of the patient puts nature's own process to work most effectively to achieve the objectives of treatment. Here are the beneficial features of dietary therapy:

Offers a solution to the related problems of obesity.

Involves little or no added expense to the patient.

May be used with complete safety.

Produces no adverse side effects.

Preferable for the long-term management of a chronic condition.

Brings about reduction of serum cholesterol through physiological processes, as yet not fully understood.

Does not usually generate new compounds in the blood, thus helping the doctor make a more accurate analysis of blood serum cholesterol.

Elevated serum cholesterol has now been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through the control of total calories and through the replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil.

An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

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Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

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ON COATS:

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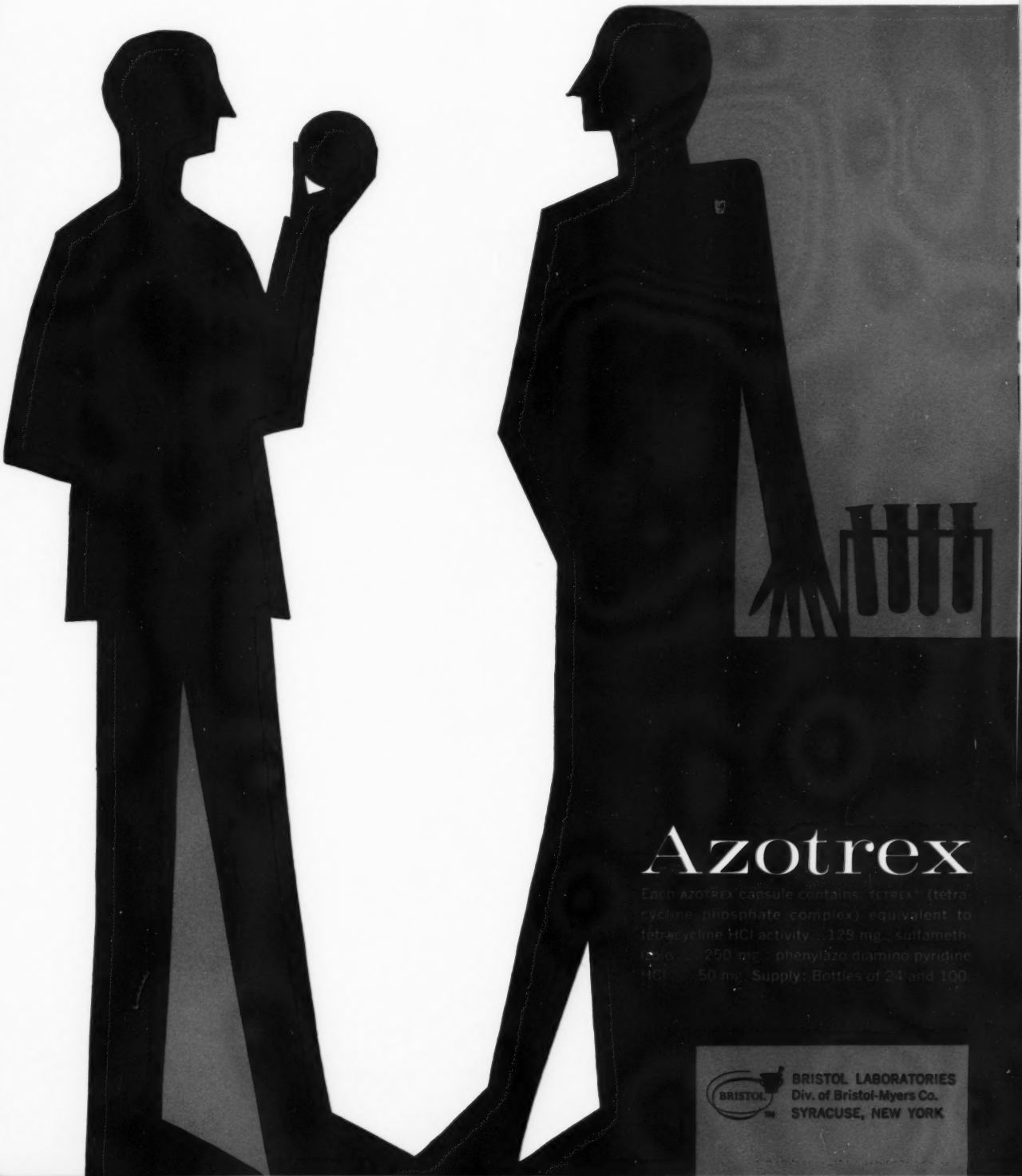
"Well, I'll send the culture to the lab, and we should hear from Bacteriology in a day or two. Now, how shall we treat her cystitis while we're waiting?"

"The chief usually orders AZOTREX. *The azo dye is an excellent urinary analgesic and the sulfamethizole and tetracycline are likely to take care of most of the bugs you find in the urinary tract. If necessary, you can switch to something else after you get the lab findings. But it probably won't be necessary."*



Azotrex

Each AZOTREX capsule contains: TETREX® (tetracycline phosphate complex) equivalent to tetracycline HCl activity ... 125 mg.; sulfamethizole ... 250 mg.; phenylazo diamino pyridine HCl ... 50 mg. Supply: Bottles of 24 and 100.

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ANOTHER YEAR OF SYMPOSIA . . .

PORTLAND, OREGON
Wednesday, January 11, 1961
The Sheraton-Portland Hotel

MONTGOMERY, ALABAMA
Friday, January 13, 1961
The Whitley Hotel

MINNEAPOLIS, MINNESOTA
Monday, January 16, 1961
The Hotel Leamington

LEMONT, ILLINOIS
Wednesday, January 18, 1961
The White Fence Farm

CINCINNATI, OHIO
Sunday, January 22, 1961
The Netherland Hilton Hotel

NEW DORP, STATEN IS., N. Y.
Wednesday, February 15, 1961
The Tavern-on-the-Green

CHARLESTON, SOUTH CAROLINA
Thursday, February 23, 1961
The Francis-Marion Hotel

ANCHORAGE, ALASKA
Saturday, February 25, 1961
The Westward Hotel

BAKERSFIELD, CALIFORNIA
Friday, March 3, 1961
The Bakersfield Hacienda

WILLIAMSBURG, VIRGINIA
Wednesday, March 8, 1961
The Williamsburg Lodge

ALBUQUERQUE, NEW MEXICO
Saturday, March 11, 1961
The Hilton Hotel

OMAHA, NEBRASKA
Thursday, March 16, 1961
The Sheraton-Fontenelle Hotel

PHOENIX, ARIZONA
Saturday, March 18, 1961
The Westward Ho Hotel

LOUISVILLE, KENTUCKY
Thursday, March 23, 1961
The Sheraton-Seelbach Hotel

BAY SHORE, LONG ISLAND, NEW YORK
Wednesday, April 12, 1961
The LaGrange Inn

BUTTE, MONTANA
Saturday, April 22, 1961
The Finlen Hotel

ITHACA, NEW YORK
Thursday, April 27, 1961
The Statler Club

ERIE, PENNSYLVANIA
Wednesday, May 3, 1961
The Hotel Lawrence

SACRAMENTO, CALIFORNIA
Wednesday, May 10, 1961
The El Dorado Hotel

LOS ANGELES, CALIFORNIA
Wednesday, June 7, 1961
The Statler Hotel

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FIORINAL®

relieves pain,
muscle spasm,
nervous tension

rapid action • non-narcotic • economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

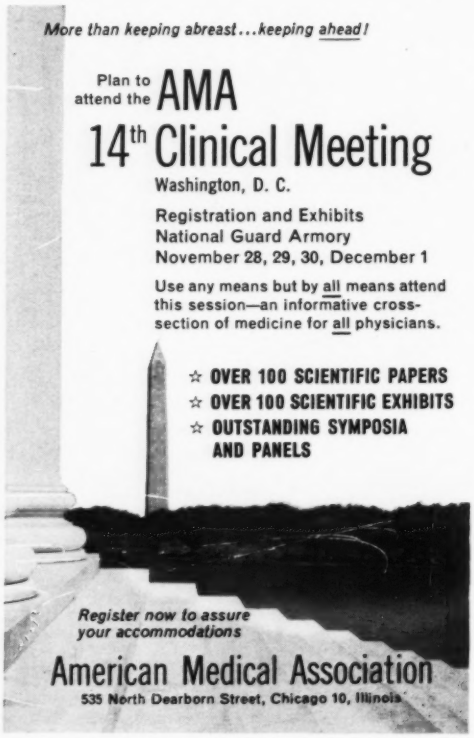
Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

Available: Fiorinal Tablets and New Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

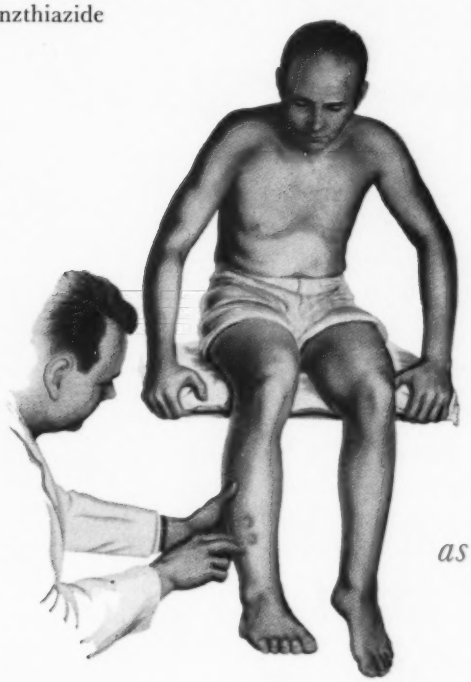
SANDOZ



NaClex®

benzthiazide

a new diuretic with an unsurpassed faculty for salt excretion



as salt goes, so goes edema

A basic principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[1]

Robins' new NaClex is a potent, oral, non-mercurial diuretic that helps reduce edema through the application of this fundamental principle. It limits the reabsorption of sodium and chloride in the renal proximal tubules (*with a relative sparing of potassium*). The body's homeostatic mechanism responds by increasing the excretion of excess extracellular water. Thus the NaClex-induced removal of salt leads to a reduction of edema.

a unique chemical structure

NaClex (benzthiazide) is a new molecule which provides a "pronounced increase in diuretic potency"[2] over its antecedent sulfonamide compound. Compared tablet for tablet with current oral diuretics, it is unsurpassed in diuretic potency.

twofold value

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with various conditions. It also has antihypertensive properties and may be used alone in mild hypertension or with other antihypertensive drugs in severer cases.

For complete dosage schedules, precautions, or other information about NaClex, please consult basic literature, package insert, or your local Robins representative, or write to the A. H. Robins Co., Inc.

Supply: Yellow, scored 50 mg. tablets.

References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

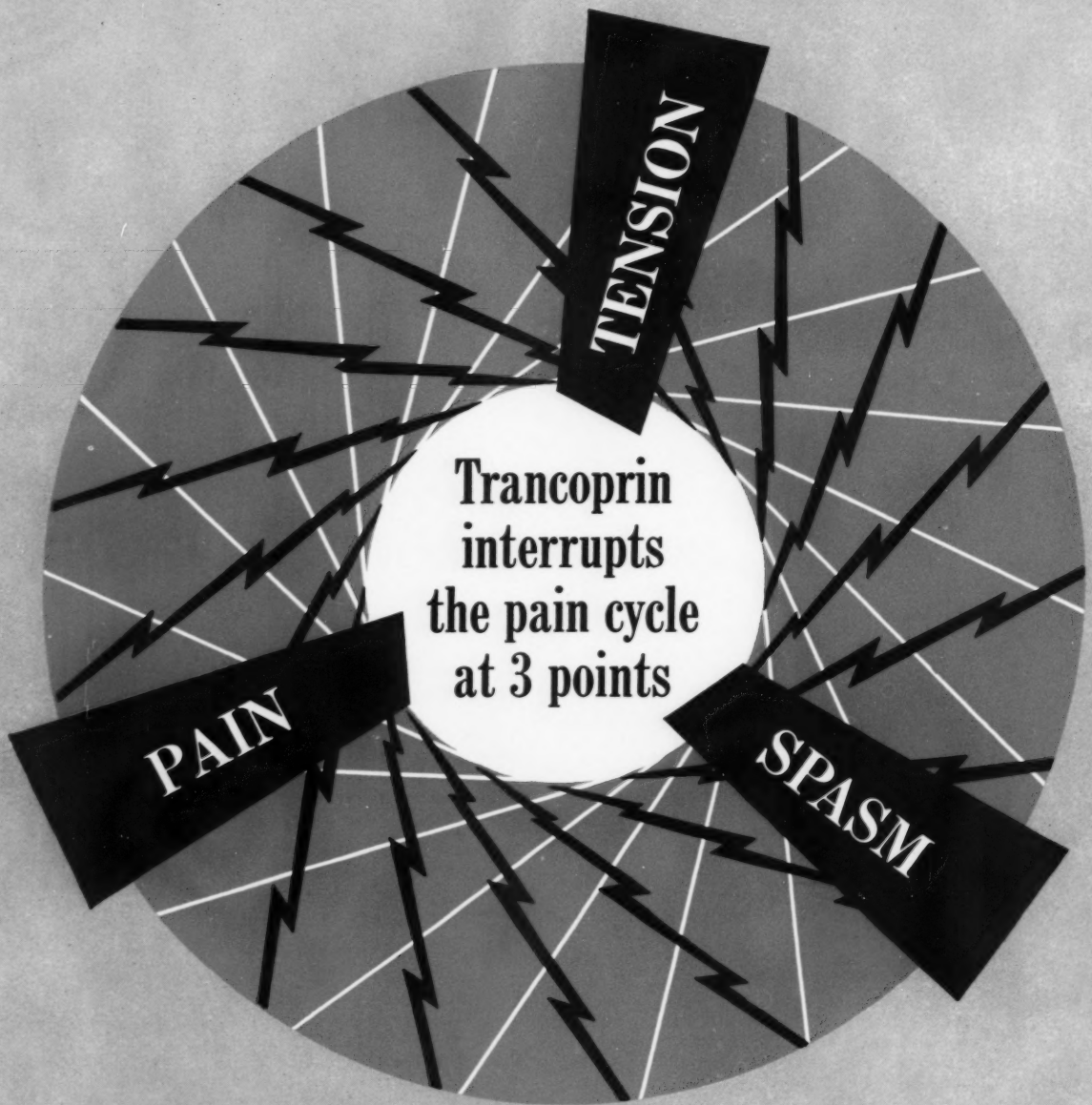
A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

announcing...

Trancoprin®

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / **non-narcotic analgesic**

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

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She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

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"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

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oxymetholone
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FOR SIGNIFICANT ANABOLIC GAINS IN: ASTHENIA (UNDERWEIGHT, ANOREXIA, LACK OF VIGOR); CONVALESCENCE FROM SURGERY OR SEVERE INFECTIONS; WASTING DISEASES; BURNS; FRACTURES; OSTEOPOROSIS; AND IN OTHER CATABOLIC STATES

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See medical brochure, available to physicians, for details of administration and dosage.

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*Reports to Department of Clinical Investigation, Parke, Davis & Company, 1958 and 1959.

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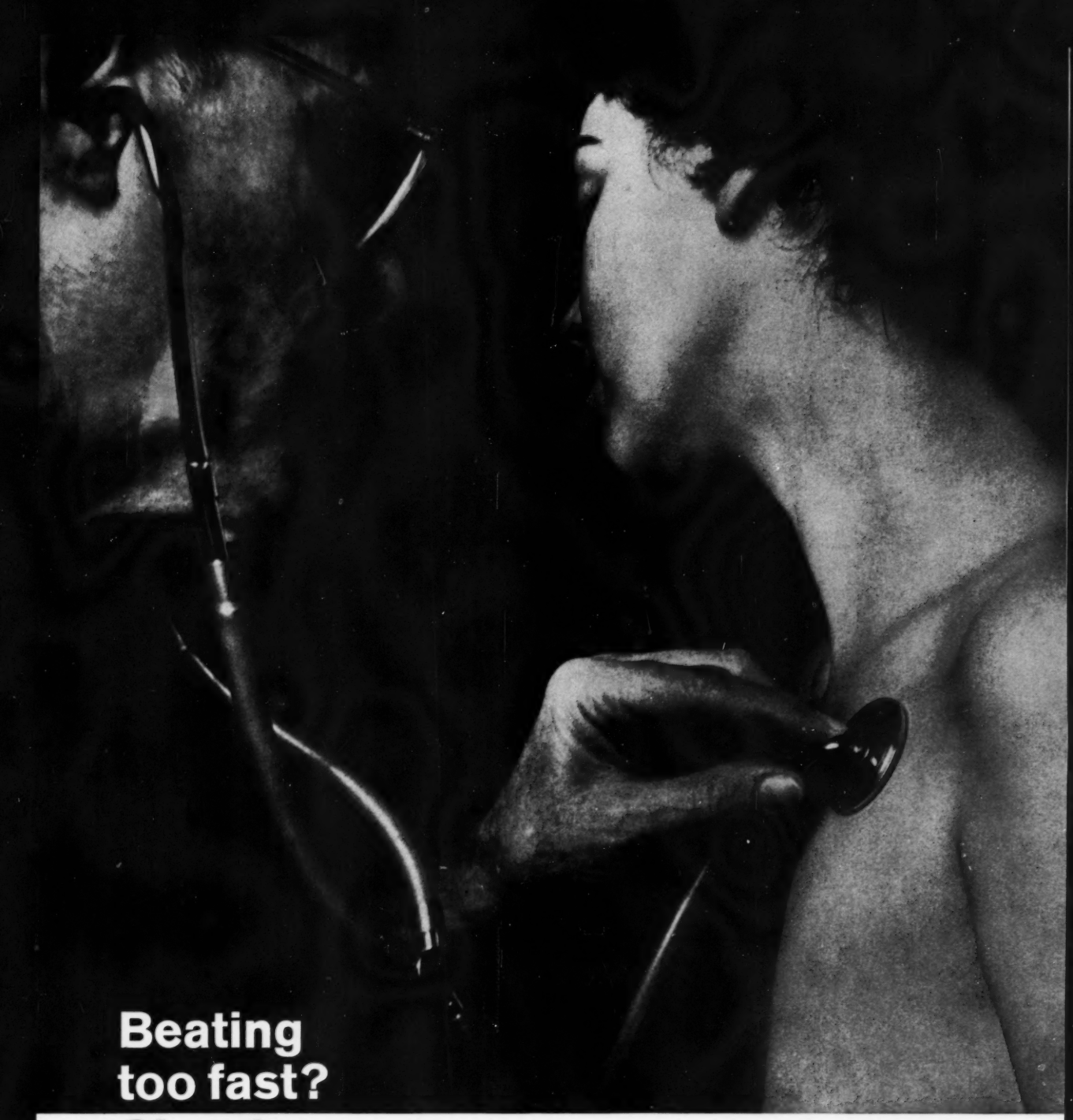

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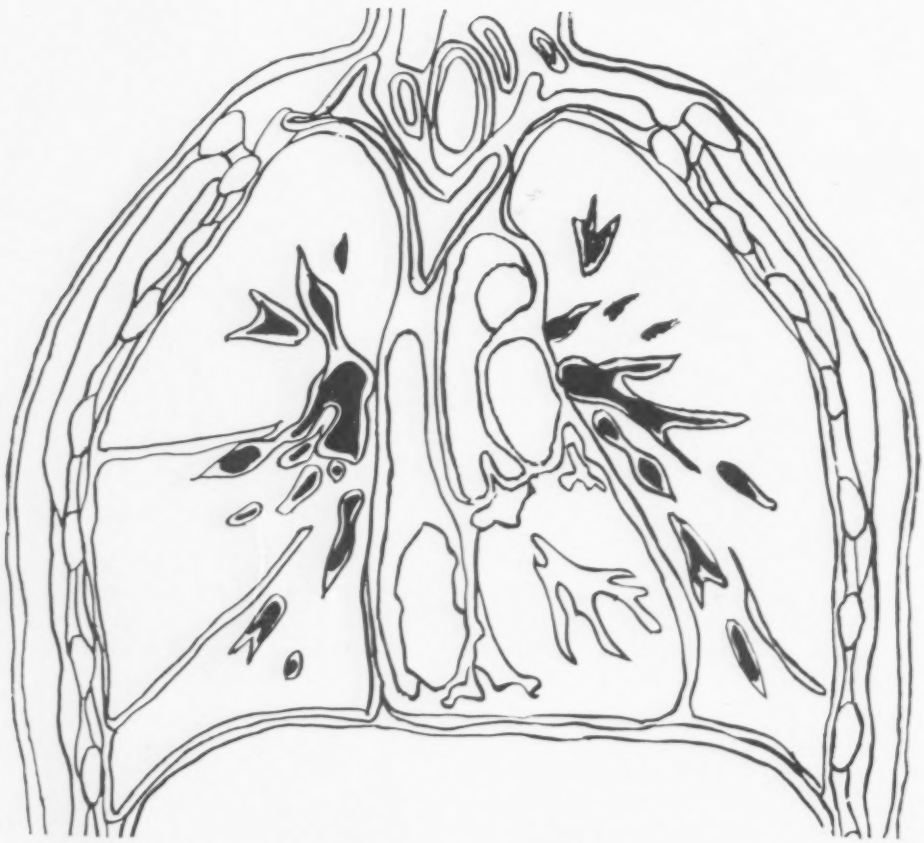

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